BEYOND PROFESSIONALISM: DEVELOPING A GROWTH MODEL FOR GRADUATE HEALTH PROFESSIONALS

by

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B.S., Marquette University, 1958
M.S., Marquette University, 1959

DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF NURSING SCIENCE

in the

GRADUATE DIVISION

(San Francisco)

of the

UNIVERSITY OF CALIFORNIA

Approved:

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Beyond Professionalism:

Developing a Growth Model for Graduate Health Professionals

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Team work is a central component of todays health care system, and will become an even more critical element in the near future when the promise of enactment of programs of national health insurance become reality. But functioning as a productive team member is dependent on an adequate sense of self and a readiness to accept others. Frequently health professionals (and especially nurses) operate from a low self-esteem stance. However, the Communications and Human Systems program has demonstrated that a modification of self-concept can occur in an intensive inter-disciplinary group laboratory which provides 1) an opportunity to acquire new information and skills that are valued, and 2) an opportunity to modify attitudes and perceptions through a group experience with significant others. In other words, the application of a feedback system can move the individual "beyond self" and "beyond profession" to a position of maximum growth.

The study of the problem "What are the effects on the self-concept of graduate health professionals of participation in an interdisciplinary group experience which focuses on communication and human systems theory"?, resulted in the following outcomes.

The general hypothesis "graduate health professionals will value an opportunity to participate in a supportive interdisciplinary group experience focusing on communication and human systems theory" was supported by the following information:

a) During the course the attendance was excellent and level of active participation was good.

b) At the end of the course REQ scores were above the mean for all six program components.

c) Following the course, 88% of the evaluation questionnaires were completed and returned.

The other general hypothesis,"graduate health professionals who participate in a supportive interdisciplinary group experience which focuses on communication and human systems theory will demonstrate a changed self-concept on completion of training" was supported generally by the subjective, qualitative data gained from the diaries and follow-up interviews.

Specific hypothesis #1) "there is a positive relationship between participation in the CHS program and self-acceptance change scores", was supported since no Time 2 group mean score of "percent positive feeling about self" of the IOU fell below the Time 1 group mean score.

Specific hypothesis #2) "there is a positive relationship between participation in the CHS program and increased self-esteem", was also supported since all groups except Group 5 showed an increased self/ideal-self correlation at Time 2 testing that was significant at the $<.05$ level (Wilcoxon T).

Specific hypothesis #3) "there is a positive relationship between self-acceptance change scores and other-acceptance change scores". There were mixed findings for hypothesis #3. The group mean on the Berger Self-acceptance Scale increased for each group at Time 2; however the expected corresponding increase in Berger Other-acceptance scores did not materialize.

Specific hypothesis #4) "there is a positive relationship between increased self-esteem and increased self-actualizaion", was strongly supported since RAT Time 2 scores increased at the $<.05$ level for 8 of 10 groups despite the stability of the instrument reported in the literature.

Specific hypothesis #5) "there is a positive relationship between increased self-esteem and increased professional self-acceptance", was not supported by the Semantic Differential since only 21 of the 57 concept

measures reached levels of significance.

Specific hypothesis #6) "there is a positive relationship between increased self-esteem and increased occupational effectiveness", was generally supported by the feedback given by colleagues and supervisors during follow-up interviews.

In addition the expectation of an ordered increase in test scores for the two post-graduate groups over four administrations (T1, T2, T3, T4) did materialize. Using the "L" test thenchange was significant at the <.01 level.

Anne H. Davis

PROLOGUE

> Unless the individual perceives his need for continued learning and growth and accepts personal responsibility for initiating steps toward learning, unless he has reduced internal barriers and blocks to his learning and unless he has learned to receive help from others and to give help to others--little continuing learning or change will take place in himself or in the social systems of which he is a part. (Benne, 1964, p.47)

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ACKNOWLEDGEMENTS

A study of this magnitude and duration could not be successfully completed without the multilevel cooperation of a great number of individuals including the Communications and Human Systems faculty and the support staff of the Mental Research Institute.

During my long association with the University of California-San Francisco Campus my growth and learning was supported and directed by many talented and dedicated instructors, especially Professor Daniel Adelson and Professor Anne Hill.

I am grateful for the technical assistance I received from each member of the dissertation committee and in addition I want to say thank you to Professor Anne Davis for contributing a most crucial reality orientation, to Professor Marian Kalkman for providing such a compelling role model-both as a unique human being and as an innovative nurse, and to Professor Barney Glaser for encouraging me to develop a new and effective way of looking at the world.

I am most appreciative of the invaluable assistance of Floyd Sorensen and Margaret Marscheck in the preparation and typing of the manuscript.

And finally I extend a special expression of gratitude to each of the 175 CHS trainees from whom I learned so much and without whom there would have been no study.

This study was supported in part by Public Health Title II Trainship (5A11 NU 00050-16) funds from the National Institutes of Health.

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CHAPTER ONE - CONTEXTUAL ELEMENTS

INTRODUCTION

For a score of years the nation has been experiencing profound changes: spreading industrialization, expanding boundaries of professional knowledge, technological advances, the population explosion, mass unrest, and social upheaval. All of these factors contribute to the difficulties that must be faced by professionals who function in such a complex environment. No where is this more evident than in the health field where the new philosophy of 'health as a right' has created service demands far beyond the capacity of existing programs.

It is not surprising that the evolutional crises of nursing (Storlie, 1970) have coincided with the knowledge expansion of the 60's and with the advanced medical technology and socio-economic changes of the 70's. With some tredpidation nursing, along with other health professions, has sought answers by exploring expanded roles, new roles, and redivision of labor (Mereness, 1970). Understandably, these efforts frequently have not achieved the desired success. One solution proposed has been to modify the undergraduate curriculum in order to increase interdisciplinary exposure and provide opportunities for mutual problem solving. But what of the graduates of five, ten, and twenty years ago who presently hold responsible supervisory and administrative positions? This paper describes a program that was designed expecially to meet some of the needs of these graduate health professionals, expecially nurses.

CHANGING HEALTH CARE

The twentieth century has been characterized by changes in the humanities, the sciences and technology. These changes in turn helped define one of the National Institute of Health goals for the 70's. High priority has been given to the establishment of a system of comprehensive health care i.e., a coordinated network of differentiated services to meet the diverse health needs of all members of the community (Szasz, 1970). This complex commitment has brought professionals of different backgrounds into the health field and highlighted the need for effective teamwork.

Lee (1969), Gallagher (1969), and Pellegrino (1969) all emphasize that today's foremost challenge is to close the gaps in health care and make adequate service available to all.

In 1966, Ruesch was predicting that the health team would soon replace the solo operator. More recently, Magraw (1968), Pellegrino (1969), and Lewis (1969) warned that the current crises in health care could be solved only by effective, innovative, interdisciplinary teamwork meshed into an integrated, comprehensive system.

As Zander (1957) has pointed out, teamwork among persons in different disciplines, professions, or occupations is one of the important sources of strength in a complex, modern society. Yet, true cooperation seems difficult to attain because each professional brings his own point of view and role behavior to the collaborative relationship.

Especially relevant to this study is Flarshein's observation (1966) that today's nurses have no clear image of where they stand in relation to the other members of the team. A brief review of the recent trends in nursing will help to place Flarshein's comment in perspective.

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NURSING EVOLUTION

Nursing, which was fashioned in the Nightingale image of a charitable service, was dominated for a number of years by in-hospital schools. In 1952, ninety-two percent of new graduates came from hospital controlled programs (Levine, 1969). These diploma programs prepared nurse generalists (Brown, 1948). All nurses could perform all nursing tasks on all nursing service units. At that time, the diploma nurse who sought a graduate education earned a degree in a specialized functional area, such as nursing administration or nursing education.

Because of the movement to upgrade nursing and because of the financial assistance provided by the Nurse Traineeship Act of 1956, the college and university based programs gained greater acceptance in the mid-fifties. The graduate of the degree program, who was still described as a 'beginning practitioner in nursing', was in many instances more a 'humanist' than a 'generalist'. When this basic degree nurse decided to pursue graduate education, she earned her degree in a specialized clinical area, such as maternal and child health nursing, psychiatric nursing, or public health nursing (Orlando, 1961, Christman, 1967).

With the knowledge explosion of the 60's and the advance of medical technology in the 70's the traditional total-care, one-to-one, nurse-patient relationship (Harmer and Henderson, 1955) yielded to make room for the nursing care team (Pellegrino, 1962). The practical nurse or licensed vocational nurse with the nurses' aid and nursing attendant moved to the bedside while the registered nurse assumed the responsibility of special operational areas, such as ward administration, medications and treatments, and intravenous infusions (Henderson, 1964).

Soon some nurses were functioning in expanded roles in family

prenatal clinics, well baby clinics, and pediatric clinics as well as creating independent roles in areas as removed from the hospital setting as a court of conciliation (Sorensen, 1967) and the police department.[1]

While the convergence of many technical, social, and economic factors made these changes imperative, the rapidity and nature of the changes tended to foster tensions and role conflicts for nurses (Kalkman, 1967).

NURSE ROLE CONFLICTS

In recent years numerous authors have turned their attention to the matter of role conflict among health professionals, particularly nurses (Reissman, 1957: Johnson, 1958: Benne and Bennis, 1959: Berkowitz, 1960: Corwin, 1961: Orzack, 1961: Arnold, 1962: Mauksch, 1963: Turk and Ingles, 1963: Kramer and Baker, 1971). Based on the concepts of role as a cluster of functions that comes to be expected of a given class of worker and role-perception as the worker's conception of the kind of behavior that is appropriate to the role, role conflict occurs when role expectations and role perceptions are not mutually held. The paradoxes and conflicts which the above authors identified as being embodied in the nurse-role will be discussed briefly under the headings: 1) inter-system, 2) intra-professional, and 3) inter-professional.

Inter-System

The least notorious dilemma for the nurse is the inter-system conflict. While this conflict may be between any two disparate systems, the example that comes to mind most readily is the professional system, represented by the nurse, vs the non-professional system, represented by the family and friends of the nurse. Johnson and Martin (1958) point

out that the medical model expects a "good professional" nurse to be "therapeutic, objective, neutral and universalistic" in her relations with patients, but her family and friends expect her to be "concerned, warm, involved, and particularistic" in her relations with them. This shifting of role behavior is particularly difficult if stress factors are operative in one or both systems.

Intra-Professional

Not too surprisingly, all individuals who are nurses do not share one undisputed image of ideal nursing. The period of reorganization of the health care delivery system and the concomitant evolution of nursing practice have resulted in several role models, some of which are mutually incompatible. Mauksch (1969) contrasts the diploma programs' traditional heritage of service, submission and self-sacrifice with the contemporary commitment of degree nurses participate in balance of power and control behavior. Similarly, Corwin (1961) compares the "traditional, bureaucratic, diploma" nurse with the "contemporary, professional, degree" nurse.

Unfortunately, significant role value differences still exist between nursing service and nursing education. As Corwin also stated, "contradictions within nursing are in part a consequence of conflict of interests between the nursing faculty and hospital staff over control of the student's classroom and clinical experience-----and the student is not neutral, for it is the teaching faculty who tend to command his loyalty (p. 605)".

Inter-Professional

Inter-professional role conflict involving nurses is probably the most obvious and most publicized of the three discussed. Arnold (1962), Turk and Ingles (1963), Issacs (1965) and Stein (1968) have all written recently about the role-conflict and role-ambiguity of the doctor-nurse relationship.

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Benne and Bennis (1959) cite an example in an out-patient clinic:

> The nurses are experienced workers who have held one clinic position over several years. The doctors on the other hand, particularly those on rotation, are not at all used to the clinic. This creates an unusual situation. Although the doctor has the senior position and is supposed to give the orders, he knows less than his nurse associate, who is expected to take orders.
>
> In some cases the nurse has the delicate job of attempting to maintain the doctor's status. Gently telling him what to do, she must at the same time appear to be obeying his orders . . . undoubtedly, this same sort of drama is played out . . . in the hospital situation (p. 382).

A similar conflict exists between nurses and hospital administrators with nurses wanting to do "real nursing" and administrators pushing for more administrative responsibility (Benne and Bennis, 1959).

The situation is summed up by Young (1969):

> The nurse who feels she is a competent professional, with the knowledge and ability to make independent judgements, finds herself trapped - on the one hand by the physician who considers her skills only ancillary to medicine and on the other hand by the administrator who unilaterally makes many decisions affecting her work (p. 63).

Many nurses cope with this frustration by seeking careers outside the hospital, expecially in teaching; and still others cope by leaving nursing altogether (Kramer and Baker, 1971).

TEAM CONFLICTS

Though the main focus thus far has been on the role conflicts experienced by nurses, it is important to note that other professionals experience similar dilemmas.

Duncan and Kempe (1968) report that there exist inherent barriers and prejudices between different types of health professionals which prevent them from working cooperatively.

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> This was evident in the response of medical students who had worked in a field health station with pediatric nurse practitioners. Neither appreciates the other's function and both feel that their knowledge is, or at least should be, superior to that of the other (p. 504).

This same uncertainty regarding interdisciplinary teamwork is reported both by Turk and Ingles (1963) and by the U.S.C. interdisciplinary Student Health Project.

> During a week of orientation the future doctors, dentists, and nurses pledged themselves to an enlightened and dignified tomorrow. -- They damned interprofessional jealousies and rivalries; exalted an image of physician and paramedical team working effectively, unselfishly, toward a common goal. To promote this type of interaction, certain projects were staffed with interdisciplinary teams. --Alas, this beautiful rapport disintegrated in a clincal setting -- interprofessional animosities mushroomed. --Uncertainty about role expectations, coupled with typically confused channels of communication led to a division of the group into enemy camps -- each faction jealously guarding its status, each insensitive to the needs of the other (Chafetz, p. 165).

Kerckhoff's study, as reported by Gross (1958) provides another example of this phenomenon. Kerckhoff asked a sample of lawyers, clergyment, social workers, and physicians to check which two professions were best prepared to do marriage counseling today. The list included the four professions and an occupation listed as "fulltime counselor". He found that all four of the professions represented in the sample checked their own profession first, and all four checked full-time counselor second. In effect, they were saying the best qualified were obviously themselves in each case, and there really was no second choice, or at least, none of the other three professions constituted a genuine second choice.

So far, we have considered some of the forces that are changing health care, discussed how nursing has responded, defined what nurse-

role conflicts have developed and identified that interdisciplinary team cooperation is difficult.

However, before a program to improve interdisciplinary effectiveness can be proposed, it is necessary to examine two of the contributory factors that seem to be central to the issue of team breakdown.

PERSONALITY FACTORS

A clue to the solution of the dilemma of team breakdown can be found in the writings of Jourad(1961), J.P.R. French (1963), Mereness (1966), Francis (1967), and Lambertson (1970). They all point out that team work and occupational effectiveness depend on a stable, mature self-concept; especially adequate self-esteem.

However, Olesen and Davis (1966), and Flarshein (1966), found that nurses as a class have a vague self-concept. Even more important is the finding regarding the nurse's individual self-concept. Davis (1969) reports a tendency for the nurse to be submissive and to sustain subordinate roles.

In his discussion of the interpersonal response traits opperative in occupational choice, Diggory (1966) reports that in selecting an ideal job, the compliant type places a high value on the opportunities to be helpful and work with people. Thus social work, medicine, teaching, social science and personnel work are chosen by those individuals who are anxious to be liked. Similar findings have been presented by Rosenberg (1957), Mauksch (1963), Korman (1969) and by Beard and Pishkin (1970).

In summary, the above studies suggest that nurses and other health professionals are individuals with vague self-concepts and interpersonal response traits indicative of low self-esteem (Krech, 1962).

Without the stable, mature self-concept and adequate self-esteem that is necessary for optimum team functioning according to the above authors, health professionals are at a decided disadvantage.

PROFESSIONAL EDUCATION

A second contributing factor relevant to the problem of cooperative team relationships would seem to be the matter of professional education itself.

The education of health professionals often occurs in the context of a single-sex, quasi-isolated student community characterized by an around-the clock concern with appropriate, ethical conduct (Mauksch, 1963). The very need for precision and the constant consideration of the ethical and legal implications in life and death matters in themselves have a constraining effect. In this kind of a stress situation, it would seem to be an obvious function of nursing and medical education to influence students' attitudes so as to bring them to a closer realization of each other's needs. "Too often, however, professional schooling tends to widen rather than obliterate the schism (Chafetz, 1966, p. 65)".

When the expansion of professional knowledge and technology resulted in a composite of behavior that was more than any one professional group could be expected to handle, a new division of labor occurred via sub-group specialization (Magraw, 1968). As each specialty developed its own nomenclature, the phenomenon of territorial imperative became more deeply entrenched (Ardrey, 1966).

So it is in these ways that professional education by its very nature becomes another inhibiting factor in establishing effective team functioning.

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SUMMARY

The orientation of 'health as a right for all' plus the goal of comprehensive health services requires first an educational system that can supply the right number and right kind of trained individuals and second a resiliant organizational network within which health professionals can form collaborative team relationships (Szasz, 1970). However, as Duncan and Kempe warn "it is naive to feel --- that simply by placing diverse skills in one setting there will emerge of necessity a comprehensive and meaningful product (1968, p. 501)".

Innovative, interdisciplinary teamwork depends on functional communication and a stable, mature self-concept. As a group, however, health professionals are often lacking in these areas. Mereness (1966) suggests "One way to help the nurse cope is to provide experience which will alter the professional self-image which in turn guides conduct and dictates action" (p.100). Rogers (1955), Rubins (1963), Truax et al (1968), and Coleman and Glofka (1969) all maintain that a structured group experience can produce positive changes in the self-concept which in turn fosters improved interpersonal relationships.

This paper is a case history (Glaser and Strauss, 1967) of a group training program that was designed expecially to meet some of the needs of graduate health professionals, primarily nurses.

STATEMENT OF THE PROBLEM

What are the effects on the self-concept of graduate health professionals of participation in an interdisciplinary group experience focusing on communication and human systems theory?

GENERAL HYPOTHESES

1) Graduate health professionals will value an opportunity to participate in a supportive interdisciplinary group experience focusing on communication and human systems theory.

2) Graduate health professionals who participate in a supportive interdisciplinary group experience which focuses on communication and human systems theory will demonstrate a changed self-concept on completion of training.

SPECIFIC HYPOTHESES

1) There is a positive relationship between participation in the Communication and Human Systems (CHS) program and self-acceptance change scores.

2) There is a positive relationship between participation in the CHS program and increased self-esteem.

3) There is a positive relationship between self-acceptance change scores and other-acceptance change scores.

4) There is a positive relationship between increased self-esteem and increased self-actualization.

5) There is a positive relationship between increased self-esteem and increased professional self-acceptance.

6) There is a positive relationship between increased self-esteem and increased occupational effectiveness.

CHAPTER TWO - REVIEW OF THE LITERATURE

This chapter will present a review of the literature in order to establish a theoretical basis for the dependent variable, self-concept and in order to provide a theoretical orientation and identify special characteristics of the two independent variables, group laboratory process and group laboratory content.

SELF - CONCEPT: THE DEPENDENT VARIABLE

At the turn of the century because of the emphasis on scientific psychology, little attention was being focused on the concept of the self. But in recent years with the emergence of the psychology of personality, the tide has turned and psychologists have rediscovered "self." The most influential researchers have been those who deal with the "phenomenological" notion of the "self-concept" (Raimy, 1943). The phenomenal self "includes those parts of the phenomenal field which the individual has differentiated as definite and fairly stable characteristics of himself (Snygg and Combs, 1949, p. 112)".

William James (1950) described self in this way:

> In its widest possible sense man's self is the sum total of all that he can call his; not only his body and his psychic powers, but his clothes and his house, his wife and his children, his ancestors and friends, his reputation and works, his lands and horses and yacht and bank account (p. 291).

According to Rogers (1951):

> The self-concept or self-structure may be thought

> of as an organized configuration of perceptions of the self which are admissible to awareness. It is composed of such elements as the perceptions of one's characteristics and abilities; the percepts and concepts of the self in relation to others and to the environment; the value qualities which are perceived as associated with experiences and objects; and goals and ideals which are perceived as having positive or negative valence (p. 136).

Other definitions are not so expansive. P. Smith (1962, P. 331) lists six dimensions of the self concept:

1) Self-confidence (self-acceptance)
2) Social worth (inner worth or moral fiber)
3) Corpulence (physical size)
4) Potency (psychological and physical strength)
5) Independence (intelligence and leadership ability)
6) Tension-discomfort (immediate feeling states)

Cooley (1902), Mead (1934), and Sullivan (1953) all maintain that an individual's self-concept develops in the course of interaction with "significant others."

Even more specific is the study by Kuhn and McPartland (1954) which suggests that the conception of the self as a member of groups and classes takes priority over other self-conceptions.

This finding is supported by Krech, et al (1962).

> The self is a product of social interaction and tends to be defined in terms of reference groups: those to which a person belongs and those to which he aspires to belong (p. 84).

Self-esteem is considered by many to be the cornerstone factor in the self-concept. Cohen (1959, p. 103) defines self-esteem as the "discrepancy between the ideal model one sets for himself and his actual self-conception." Horney (1939) and Fromm (1939) believed that low self-esteem was a by-product of the suppression by the family or the culture of individual spontaneity. They also report that low self-esteem individuals have a basic hostility (or non-accepting attitude) toward others.

Coopersmith (1964, p. 218) makes an interesting contribution by

delineating types of self-esteem. These are derived by combining the individual's self-evaluation (S.E.I.) and an observer's rating on self-esteem behavior (B.R.F.)

TABLE 1

Types of Self-Esteem

Types	S.E.I. + B.R.F.	Comments
High-High	H H	Above average socially and academically. Satisfied with personal performance.
High-Low	H L	Striving to maintain positive self-evaluation in face of disconfirming evidence.
Med.-Med.	M M	Average typical individual for given age group.
Low-High	L H	Successful, gifted; but striving for ideal goals.
Low-Low	L L	Inferior performance. Low level of ability.

An increasing body of experimental and clinical evidence points to the important role of self-esteem in determining behavior. Self-esteem has been related to the nature of defenses (Cohen, 1959), motivation (Coopersmith, 1960), identification (Stotland and Hillmer, 1962), persuasibility (Leventhal and Perloe, 1962; Silverman, 1964), and attitude change (Dobbs, 1964).

The diversity of this evidence also suggests that self-esteem exerts a pervasive influence - an assumption strongly supported by factor analytic studies of the self-concept (Osgood et al, 1957; Smith, 1962).

Further, the findings of Witkins and Associates (1962) reveal that persons who can orient themselves to space tend to be high in self-esteem, actively involved with their environment, and significantly more anyalytical and differential in their clinical and experimental responses.

Another important aspect of the self-concept is a "conscious realistic recognition of some falling short of the ideal; that is, respecting oneself, including faults." Berger (1955) has demonstrated that self-acceptance is closely linked to other-acceptance. Likewise, Adler (1924), Fromm (1939), Horney (1939), and Murphy (1947) all theorized that if an individual's growth experiences are such that he forms an unlovable, self-rejecting image, a basic hostility arises which is expressed in the form of vague and general criticisms of other individuals and groups.

Finally, another factor of the self-concept which has relevance for this project is self-actualization or the state which enables a person to best express his individuality and originality and most completely develop his full potential (Diggory, 1962). Wenkert (1955) postulates that self-acceptance is a premise to inner growth and as such opens the road to ingenuity and creativity.

GROUP LABORATORY PROCESS: AN INDEPENDENT VARIABLE

The experimental findings of Wallen (1963), Flarshein (1966) and Felton (1967) add evidence to support the contention that shared participation in an educational experience 1) produces more effective and positive values in learning, 2) increases retention of material and 3) increases the ability to generalize to other situations.

In the laboratory situation Beaty (1965) found that interacting

individuals accelerate the decision process and that the predictions made after social interaction exceeded chance accuracy. He concludes, these findings "are consistent with knowledge about the relative performance of individuals and groups in problem-solving situations (p. 306)".

Lewin (1935) was one of the first to recognize the impact of group decisions upon social change. He generalized it is usually easier to change the opinions and attitudes of individuals formed into a group than to change any one of them separately.

> The acceptance of the new system is linked with the acceptance of a specific group, a particular role, a definite source of authority, as new points of reference. It is basic for re-education that this linkage between acceptance of new facts or values and acceptance of certain groups or roles is very intimate and that the second frequently is a prerequisite forthe first (Lewin and Grabbe, 1945, p. 64).

Studies by Havighurst and Orr (1956), Bernstein et al (1954) and Nunnaly and Osgood (1961) have demonstrated that existing value systems can be modified through a situational and problem-solving approach that recognizes the need of tying the new knowledge to the individual's own emotional and intellectual experiences.

While nursing education traditionally has been concerned with the dyadic nurse-patient relationship, current literature is strongly emphasizing the importance of the nurse's role as a member of the health team and with other groups.

Numerous authors have specifically recommended group experiences for nurses, among them Thompson (1965), Carter (1967), Fortune (1970), Yeaworth (1970), Lange (1970), Flarshein (1966), and Daly and Heine (1970) reported increased co-worker acceptance and improved nursing competence following group experience. Frerichs (1966) states: "A

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nurse spends much of her professional time interacting within a group setting. Her professional judgements are influenced and evaluated by other members of the health team. Nurses, therefore, must have opportunities to learn how to be capable group members (p. 6)".

Likewise, several medical education programs such as the University of San Marco (Seguin, 1965), Stanford (Yalom, 1966) and Menninger Clinic (Ammon, 1967) have reported success with group teaching methods.

Ammon (1967) and Andronico (1967) have related accounts of successful programs which combined didactic and dynamic elements in group work.

In addition to the comments about groups in general, some authors have addressed themselves to the question of the specificity of groups.

Morgan and King (1966) and Vinacke (1968) observed that primary groups, which consist of friends and close associates, help shape a person's attitudes. Similarly, in relation to self-esteem and self-actualization Adelson (1967) has suggested the formation of small groups "in which individuals will find a sense of belonging and positive valuation of their own characteristics (p. 8)".

One such activity, a group therapy program begun in 1966 for the Sausalito Police Department, has had notable success.

> I've never seen a department with better morale. These men are dispelling the stereotyped notion of the dumb, arrogant cop. Arrests have tripled in the two years, but no one has accused us of overpolicing or made a single accusation against any of the police. Sausalito citizens are far more cooperative, far more interested and far more responsive in their relations with the police (Earle, 1968).

Sensitivity group experiences have also enabled probation officers to develop increased sensitivity to themselves and the people around them (WICHE, 1968).

The conclusion of the author, based on personal experience and

supported by the above data, was that some form of group laboratory activity would be the most appropriate program format.

Of the various group approaches, the T-Group Laboratory Method as described by Stock (1964) seemed most suitable.

> It is difficult to separate out any single aspect of a laboratory and say this is what influenced learning. The laboratory is designed to include presentations of theory, and demonstration and practice sessions on the assumption that these plus the T-Group constitute an integrated whole (p. 421).

In recommending T-Group method Seguin (1965) reports that the students profited from discussing their perceptual distortions, learning the way the mechanism functions and finding ways to minimize distortion.

Thompson (1965) has stated:

> Sensitivity training is a means whereby individuals learn about interpersonal interactions and group process through direct experience. In encouraging self-study, the technique becomes an educational device which offers potential for generalizing to other interpersonal situations (p. 132).

Frye's (1966) report that task-oriented individuals tend to have low self-esteem but that successful group experience tends to increase self-esteem may have special significance in view of Mauksch's observation that nurses tend to have low self-esteem.

Yalom (1966) also found that students who participated in T-Groups developed an increased degree of confidence and self-awareness. The anxiety-reducing function of open discussions in a trusting atmosphere was especially valued by the students.

Similarly, Miles (1964) states: "T-Group members find that never before have they been in such a supportive and personally compelling learning environment (p. 470)".

At the conclusion of his review of the literature, House (1967)

summarizes his findings:

> The above argument offers ample evidence that the T-Group Laboratory Method is a potentially powerful tool for changing behavior and is differentially effective in a wide variety of situations with a wide variety of individuals (p. 29).

Garner (1965) describes the value of such an experience as follows:

> Not only are knowledge and skill acquired in the area of group dynamics, but further, individuals learn ways of communicating more effectively, ways of participating in the group experience more successfully, and ways of working together more cooperatively. Thus they begin to alter habits of behavior in relation to the needs and demands of the situation at hand. Members learn ways of adjusting to change, ways of realistically balancing their own expectations in relation to the expectations of others, and ways of disciplining their own personal desires (p. 147).

However, Odiorne (1963), House (1967) and Fortune (1970) have commented on the drawbacks of sensitivity groups. The T-Group Method controversy centers around the tremendous amount of dollar and human resources currently being directed to the method, the question of the value of the experience, and the question of the danger to the participant of some psychological damage.

House concludes that the chances for a successful group experience are increased by incorporating the following basic recommendations:

1. Have well-defined goals.
2. Select leader (or leaders) carefully.
3. Select participants carefully.
4. Start with detailed explanations of goals and process.
5. Provide "way out" if anyone changes his mind.

In utilizing the group laboratory method, the group composition with relation to size, age, sex, personality and professional discipline

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is of fundamental importance.

The Macomber and Siegel (1957) experiments at Miami University found statistically significant differences favoring the smaller classes, particularly for high-ability students. Similarly, a study by Schellenberg (1959) found higher student satisfaction and higher instructor grading in smaller groups. McKeachie (1963) points out that, with increasing size, group members are likely to feel restraints against participation with the result that group activity is increasingly dominated by a few people. Finally, Miles (1964) suggests that a typical T-Group consists of eight to twenty adults, divided into sub-groups of four to five people.

In relation to age, Miles (1964) comments:

> The presence of a wide age range and perception of the leader as falling within it are probably major forces in defining the T-Group task as a cooperative struggle to construct a workable social system which will aid learning (p. 457).

Whitman (1964) reports that the way men and women participate in a group can be sharply delineated. Females conform more (Reitan, 1964) and are less differential and more favorable in perceptions than males. However, both Reitan (1964) and Amidjaja (1965) call attention to the complexity of determining variables and suggest the need for further research.

Homogeneous grouping by personality proved to be ineffective in Hoffman's 1959 experiment in group problem solving (McKeachie, 1963), while Heslin (1964) concludes: "Within the constraints imposed by situational and social variables, personality characteristics do influence group processes (p. 255)".

The Western Reserve School of Medicine which pioneered with multi-disciplinary teaching, the Cornell Comprehensive Care and Teaching

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Program (Reader, 1967) and the University of Southern California Student Health Project (McGarvey, 1966) have all reported encouraging results with interdisciplinary activities.

Yeager (1962) reports that graduates in professional disciplines are often handicapped by role prescriptions and "tunnel vision" which results in a narrow view of community health problems. However, combining professionals from various disciplines into a team working on the same problem presents them with a totally new and universally appreciated educational experience (McGarvey, 1966). Also, structured group experiences help professionals to examine the consequences of their acts for one another and to plan ways of eliminating situational effects which cause insecurity and strain in inter-role behavior (Zander, 1957). In addition, the opportunity for shared experiences in professional education is a powerful antidote to the crystallization of professional postures which prohibits real communication (Pellegrino, 1966).

Stock (1964), Yalom (1965) and Satir (1968) hold that group heterogenity, which duplicates real life situations, makes a wide range of issues available for exploration, thereby maximizing the growth potential.

Stock (1964) summarizes that in setting up a group laboratory experience, members should be homogeneous in characteristics such as intellegence, job competency, and emotional stability, but heterogeneous with respect to age, sex, personality and occupation.

GROUP LABORATORY CONTENT: AN INDEPENDENT VARIABLE

Content is one important factor of the total laboratory experience. The degree of commitment a participant makes is partly determined by the value the individual places on the information being exchanged. As

Tyler (1966) points out:

> Not only are knowledge and information increasing rapidly, but changes are also taking place in the skills and attitudes required in various fields. The result is that educators are trying to figure out what it is they can help students acquire that will have some permanent value (p. 1396).

The changing role of the professional nurse in hospitals, in health agencies, in industry, and in the community has emphasized the necessity for expertness in the art and science of communication (Jessee, 1965). Interprofessional relationships are founded largely on verbal and non-verbal communications (Muller, 1962). However, there is a growing communication crisis in the health professions today and the resultant cacophony is reminiscent of the proverbial Tower of Babel (Pellegrino, 1966).

Watzlawick (1967) sums up the importance of communication. All behavior is communication -- one cannot not communicate.

Ruesch (1966) and Satir (1968) hold that emphasis on communication is so vital because information controls action. It is at the communication level (integrative process) that choice occurs and therefore where change is possible.

It has been speculated that the very fact that communication is "all-around" and "ever-present" may explain why the process is taken for granted and assumed to be automatic. It then follows that providing an experience for nurses and other health professionals whereby the communication process is brought to the conscious level could result in their using communication much more effectively.

This communication, or relating, has four basic patterns: an individual in relation to himself; an individual in relation to another individual; an individual in relation to a group; and a group in relation to another group. Ruesch (1966) further concluded that, since man's very existence

depends on his ability to exchange information and to remain connected with his fellow man, constructs such as society and culture are simply different aspects of one basic function -- communication.

It was this concern with communication as a central factor in human culture and organization that led to the definition of the second fundamental concept -- human system theory.

Sociologists such as Talcott Parsons (1951) maintain that since significant aspects of man's behavior are a product of the groups to which he belongs at any moment in time and of the many groups which have influenced him in the past, behavior cannot be fully understood or explained unless one takes account of human system theory.

System is defined by Webster as an organization or assemblage of objects united in some form of regular interaction or interdependence. In system theory, then, the emphasis is on the variety and complexity of inter-related parts and on the whole which is greater than the sum of these parts.

A major goal of professional education is to build a team with therapeutic skills -- with the ability to bring health to the families, work groups, social groups and community organizations in which they find themselves. But skill is more than knowledge and that is why effective understanding of systems is built around the participant learning group (Baumgartel, 1964). The individuals who participate in the group experience develop integrative bonds with one another, and, in the process of resolving difficulties that arise while accomplishing this, create a social organism or system (Brussel, 1967).

In addition to the group, another system that lends itself to first-hand observation is the family system. The family, which is still the primary biosocial unit in our culture, is also the ultimate source of all

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other social systems. Behavior originates in the individual within the family and is projected to the larger community.

Increased understanding of the family system has immediate application for members of the community health team. Modern health trends have moved from patient-oriented programs to population-oriented programs with the emphasis on individuals in groups -- particularly the family group (Ruesch, 1966). In addition, understanding gained from family systems can be generalized to other systems since the same general rules apply (Parsons, 1951).

SUMMARY

The review of the literature has established the importance of self-concept as an "organizing gestalt" in the understanding of behavior and further identified the cluster of factors (self-esteem, self-acceptance, other-acceptance, and self-actualization) which constitute the gestalt.

On the basis of the review of the literature, the group laboratory process emerged as the most appropriate method to utilize in developing and implementing a program which offers an opportunity for an individual to modify attitudes and perceptions of self.

Communication theory and system theory were selected as the didactic focus because of their relevance at both the content and process levels.

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CHAPTER THREE - METHODOLOGY

This chapter will detail how the problem to be studied was translated and implemented as a training program for graduate health professionals called Communication and Human Systems (CHS).[2] After defining pertinent terms and describing the setting, the focus will shift to a description of the program and the program participants. This will be followed by a discussion of the evaluation design which will include methods of evaluating the program as well as methods of evaluating the individuals and the groups who participated in the program.

DEFINITION OF TERMS

Health: the state of complete physical, mental, emotional, and social well-being.

Health Professional: any helping or intervention agent in the community (in accordance with the World Health Organization philosophy which considers the individual in the context of this total environment).

Self-Concept: a generic construct in the area of self-psychology which encompasses such factors as perceived self, ideal self, self-esteem, self-acceptance, and self-actualization (Snygg and Combs, 1949; Wylie, 1961).

Perceived Self (phenomenal self): an organized configuration of perceptions of the self which are admissible to awareness (Krech, 1962).

Self-Esteem: measure of the descrepancy between the ideal model and the perceived self (Cohen, 1959; Wylie, 1961).

Self-Acceptance: conscious (realistic) recognition of some falling short of the ideal; respecting oneself, including faults (Wylie, 1961; Wenkert, 1955).

Self-Actualization: "realizing" self in terms of unique capacities and individual organic destiny (Diggory, 1962).

THE SETTING: TIME AND PLACE

The duration of the study was four and one-half years: from January 1968 through June 1972. The study was conducted at the Mental Research Institute (MRI). MRI, a private, non-profit behavioral and social science research-training institute focusing on the study of man in the family and the community, is located in Palo Alto, California. MRI owns a two story brick building in central Palo Alto which contains attractive offices on both floors. A training laboratory with facilities for observation of trainees was available on the second floor. Facilities for video and audio recording are built in. The building also contains a conference room on the first floor which can accomodate a meeting or seminar with forty participants.

Duncan and Kempe (1968) comment on the value of offering such an interdisciplinary program away from either the academic or work situation: "As the distance from the agency increases, there is a greater likelihood that the students will accept each other as individuals and equals (p. 502)".

THE SPECIAL CHS PROGRAM

Communication and Human Systems, an intensive three month, inter-

disciplinary, coeducational program, was designed to increase theoretical and experimental understanding of one's own uniqueness as it contributes to personal and professional effectiveness, individual and group behavior, a general systems, or cybernetic, grasp of interpersonal behavior, the implications of systems and role theory for interdisciplinary cooperation, relevant evaluation and research activities and applications.

The program was also designed to foster the integration and application of the learning experience into personal and professional behavior.

Organization

Guided by the preceding goals a general plan was formulated for the three month training program. This plan is presented in Table 2.

In implementing the program goals, the intensive three-month course incorporated a variety of learning experiences, including lectures, seminars, encounter groups, role-playing, demonstrations, and field placements. Observation suites, audio and videotaping facilities, and the professional library were also utilized in training. For samples of specific class schedules see Appendix A.

Classes were composed of about fourteen students (Bales and Borgatta, 1955) and, in order to provide a truly comparative approach to systems, males from various related disciplines comprised half of each group. The program differed for men in that no stipends were available, although scholarships to cover tuition fees were provided. Therefore, men accepted for the program did not participate in the community placement program. However, nurses were given the opportunity to function in a community agency for approximately 15-20 hours per week. The purpose of the field placement was two-fold: 1) to

provide a laboratory for practical application of class work in an actual work setting, 2) and to expose nurses to currently evolving roles and new patterns of practice in settings outside of the hospital which they may not previously have had the time and opportunity to explore. Placements were assigned after consultation with the trainee, and every effort was made to place her in an area fitting her interests (Duncan and Kempe, 1968).

Time allocation for the two days per week at MRI was about as follows: 25% for didactic theory presentations; 50% dynamic seminar meetings which included discussions focused on group process as well as substantive content, field work reports in relation to theoretical issues, family therapy demonstrations (including brief therapy techniques), work system simulations, and a variety of videotape exercises and experiences; 20% encounter group experiences, including a 24-hour laboratory experience; and 5% evaluation participation designed to provide additional learning experiences in relation to consolidating and integrating the trainees' grasp of each of the foregoing areas, while also providing a basis for assessing the course impact and for systematically generating further course improvements.

Staff

The most central element in any program is the staff. The individuals who planned and carried out the CHS program were especially chosen for their diversity in personalities and backgrounds, age, sex, and profession. This was done to provide a concrete example of appreciating one's own uniqueness. That is, people from different disciplines with different approaches were able to work together and respect each other's contribution to the program. It also provided trainees with more options of people with whom they could relate comfortably. While this diversity

was considered a strength in the program, insuring that the program would be diversified but not disorganized proved to be an organizational and administrative challenge. Ongoing administrative meetings and faculty meetings helped to build bridges and provide some coordination for the people in the program. Fortunately, the nurses on the staff were MRI graduates. Also, all staff members had known each other over a period of time and were more able to work out their relationships and trust problems than if they had been meeting as total strangers. And, probably more important, they were people who were generally committed to the goal of sharing information.

Having said that the program was fortunate in having a creative, dedicated and diversified staff, may give the impression that coordination and implementation were a simple matter. In fact, nothing could be further from the truth. Probably each staff member had said at one time or another in the pre-CHS days, "If I were teaching those students", and yet when CHS offered a creative opportunity, the first reaction was to be awed almost to the point of being immobile. This seemed to be followed by the "trying too hard" phase, with each person truly committed to the approach he felt offered real promise. The problems would come about because generally no two approaches meshed together. Fortunately, the group next shifted into the negotiation phase and the hard work of putting together a viable program began in earnest.

Recruitment

Another challenge was to come up with a brochure that was attractive, would stimulate interest, would clearly state what the program was about, and, in addition, answer practical questions that an individual might have about eligibility for and application to the program. This posed two problems. First of all, a dynamic program is difficult to

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TABLE 2

Curriculum Design

Input	Integration	Evaluation
Communication Theory Seminars General Systems Theory Cybernetics Game Theory Communication Patterns Paradox	Communication Games Videotaping Exercises	Seminar Discussions Observer Feedback
Group Dynamics Seminars History Terminology Representative Theories	Communication Groups T-Groups Marathon	Seminar Discussions Individual Conferences Diaries
Family Theory Seminars Definitions Rules/Roles Assessment Interventions	Simulated Families Structured Interview Demonstration Families Training Families	Observer Feedback Supervision Comments
Community Systems Seminars Management Theory Organization Theory	Problem-Solving Exercises Simulated Work Systems Field Placement Projects	Observer Feedback Individual Conferences Field Notes
Evaluation Seminars System Model Theory Evaluation Instruments	Pre- and Post-Testing	Feedback

describe concisely. Secondly, individuals, because of their own needs and motivations, often interpret information from a context different than that of the group compiling the brochure. It is not surprising that the sample brochure went through many revisions before it was in a form ready for the printers (Appendix B). Other practical questions that needed answers involved how many brochures to print in terms of the overall demand and how to keep them current? The matter of listing staff accurately was solved by having the faculty list printed on a gummed insert that could be changed as needed without having to re-print the entire brochure.

In order to get widespread publicity, ads describing the CHS program were placed in a number of the professional journals. Also, staff members made visits to local agencies to describe and discuss the course. After the program had been underway for several quarters, word of mouth advertising by former trainees (or individuals who knew former trainees) was the most productive means of recruitment.

Implementation

Initial efforts were directed toward "getting the program together" and consisted of a planning phase and pilot group phase. The planning phase involved many staff conferences, conferences with professionals in the community (with educators, with supervisors and with the workers on the line in agencies) as well as a review of the literature. The outcomes of these considerations resulted in a setting of content and context priorities as illustrated in Table 2. To test these priorities, the pilot group approach was utilized. Out of the experiences with the two pilot groups, a modified schedule emerged which remained relatively constant for Groups 3-12 (Appendix A).

As can be seen from Table 2, a variety of dynamic learning techniques were included in the program. For example, each student had at least one opportunity to negotiate for and play a role in a "simulated family". This was to give the trainee an opportunity to experience the kinds of events that "set" systems and also to discover how system sets influence individual behavior. Role-playing a large family helped to clarify how to set priorities and define options in a very complex system (Moreno, 1936 and Bavelas, 1947).

Two other activities that proved valuable were the integration laboratory (Mosel, 1964) and the system laboratory (Kahn and Cannell, 1957). The integration laboratory was a relatively unstructured period of time when staff and trainees met to rap about the ongoing experience and their attempts to put the pieces together--that is, to integrate theory and practices. The system laboratory was similar, but more analytically oriented. There, trainees had an opportunity to describe their work setting and to role-play situations from this system in order to get direct feedback from both trainees and videotape. In addition, trainees had an opportunity to do what was called a "rehearsal for reality"; i.e., role-play a pending job interview situation.

Problem-solving exercises were also an integral part of the program (Boocock, 1968). These enabled trainees to get direct feedback about their functioning in a task-oriented situation. One activity in particlar, the "moon landing" exercise, provided a wealth of material because it was an "imaginary" situation and therefore was not experienced in as emotionally-loaded a manner as the discussions and explorations that occurred in the group dynamics situations. As such, many individuals could more readily incorporate this kind of feedback.

Among the training tools available for the CHS program were videotape

and film sessions (Berger, 1970) of family therapy as demonstrated by various experts (Jackson, Ackerman, Whitaker, Bowen, Satir). These films were originally shown as part of the regular classwork. However, due to the pressure of time and the fact that some of the trainees were already familiar with them, this part of the program was later scheduled during after-class hours, and attendance became optional

Both demonstration and training families were utilized in the program (Howells, 1968). These families were solicited from colleagues, from past trainees, or from community agencies. The training aspect of the therapy sessions was explained to all prospective clients: that is, that professional trainees would observe the sessions from view rooms, that audio recordings would be made for the purpose of trainee supervision, and that trainees also had telephone communication from the demonstration room to the viewing room, so that therapist, client and trainee could be in touch with one another. Clients were invited to tour the viewing rooms, to meet the trainess and were also given a brochure describing the CHS program. They were then asked to sign a release form (Appendix C). Rather than voicing, verbally or nonverbally, any real reluctance about the set-up of the program, most clients were very positive in their comments about the usefulness of the experience, and indeed seemed to be pleased to be a part of this kind of professional program. In fact, a few demonstration families referred their friends as clients for future training sessions.

The clients seen included couples, incomplete families and families with as many as eight children. Some families were seen only once for an evaluation session. Others were seen from three to ten times. But in all situations no fees were charged. The demonstration families were interviewed either by a single staff member, by staff members in co-therapy,

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or by one staff member and one trainee in co-therapy. Similarly, the training families were seen either by a trainee individually or by two trainees in co-therapy.

At the completion of the contract sessions, the family and the staff members would evaluate the current status of the family group to determine whether termination was appropriate. If not, follow-up was done by trainees in their work setting or referrals were made to other agencies or individuals in the community.

Frequent mention has been made of the practice of audio and/or video recording (Berger, 1970) the various activities in the program, and therefore a few explanatory remarks seem to be in order. There was almost unanimous agreement among trainees and staff that effective audio-video recording is a priceless learning experience. However, the difficulty occurs in consistently achieving an effective outcome. First of all, the equipment needs to be appropriate for the task and be in A-1 condition so as to be unquestionably reliable. Secondly, audio-video feedback usually constitutes a massive amount of data input and provisions must be made to allow the individual and group to "make sense" of the experience. The technique used as an end in itself can result in a destructive rather than constructive experience.

Group dynamics (Cartwright and Zander, 1960; Bradford et al, 1964; Burton, 1970) became a basic component of the program after the early pilot project experiences indicated that the degree to which a person had integrated his own individual and group behavior was directly related to his degree of success as a therapeutic agent. In fact, group dynamics proved to be the most sought-after part of the program, as well as the most anxiety-provoking. The structured interview elicited numerous remarks to the effect that "I am looking forward to group dynamics, pro-

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vided you use legitimate techniques and well-prepared professional leaders." In order to enable the trainee to make a decision about participation in group dynamics, position papers (Group Experience Laboratory - A Statement for Group Members) were made available (see Appendix D). Because of the range of prior experience in each group, a developmental sequence was provided, starting with group dynamics, moving to sensitivity group, and finally to group laboratory which included an 18-24 hour marathon. The marathon experience grew out of a request of the first pilot group to have an extended group meeting, which they then arranged for one of the last weeks of the program. In their evaluation, they expressed the wish that it had been earlier in the program. So the next group had a marathon in the second week. However, they reported that this was too soon for them; that enough trust had not been developed within the group. Therefore, the remainder of the groups have had the marathon scheduled in the fifth week of the program. The matter of the marathon has always been negotiated by the group itself about the third week of the program. There were options about whether to have a marathon or not, when to have it, how long to have it, where to have it, etc., and each group made its own decisions which were then reviewed by the staff.

Another technique that proved useful was to have diverse leaders for different parts of the group experience so that every individual's chances of finding someone with whom he could relate comfortably were increased. However, in several of the later programs, partly because of staff availability and partly because of trainee requests to have only one group leader throughout the course of the program, this latter approach was tried. In retrospect, it appears to be a fifty-fifty proposition with just as many trainees preferring varied leaders as those who prefer a single leader.

Schedule Modifications

On the basis of staff evaluation and feedback from trainees other shifts in emphasis did occur. For example, the 8-12 hours of class time originally set aside for guest lectures was later eliminated. The 28 hours allotted to communication theory seminars were eventually decreased to about 16 hours. Brief therapy started as a 2-hour guest lecture, and increased to 6 hours, and finally to 9 hours. Family therapy laboratory started out as a 12-hour program component but the time eventually was doubled. The earlier programs included several five-hour minithons, and these evolved into a weekly 2-hour group experience plus one marathon.[3]

According to the original schedule, the trainees were to spend mornings in class at MRI and afternoons in their work agency or a field placement. It didn't take long to discover that this was not very efficient planning. The most persuasive argument for change was found in the number of commute hours trainees were logging each week. Some came from distances of 50 to 100 miles. Therefore, the format was changed to allow for two full class days per week. On the basis of trainee preference, the days chosen were Thursday and Friday.

As the program was first conceived, trainees were to be assigned a field placement within the established public health and mental health departments of the county system. However, a survey of potential students indicated that nurses wanted to have an opportunity to develop new roles in smaller, less structured community agencies. CHS was very fortunate to find a number of vibrant and creative agencies willing to accept trainees. In considering placements, two guidelines were used by staff: first, there must be a good potential for a growth experience for both the agency and the trainee; and secondly, there must be a fit between the agency need and a predominate interest of the trainee. Because

selections were made during the first week of the program there was considerable pressure to find a fit between trainee and agency, but in most cases this was successfully accomplished. In fact, in only two situations was it decided that since the immediate placements didn't seem to fit, time could more productively be spent in evaluation--both self-evaluation and community evaluation.

Also, in the beginning, orientation and introductory material was presented to the trainees on the first day. This included permission slips (Appendix C) that needed to be signed, trainee applications to be completed, a tour of the building, introduction to staff, explanation of procedures, and other general orientation. However, this never seemed to work out too well, and it was finally determined that individual trainees built up a good deal of tension in anticipation of the program and found it a disconnecting experience to be asked to settle down to prosaic paper-and-pencil tasks. Therefore, midway through the study, the schedule was reorganized, and the first day of the program consisted of a half-hour paperwork and instruction session followed by a coffee hour which enabled staff and trainees to get to know each other. Then, the rest of the time was spent in videotaping exercises. This proved to be a very full and hectic first day, but seemed to serve the purpose of channeling the anxiety and energies that had been generated as well as fostering group cohesiveness.

As groups grew in size from 9 to 14 students, it became increasingly difficult to see that each person had a place, or to see that each one "got a slice of the pie." The staff believes 10 is an ideal number, 12 is workable, and 14 becomes rather difficult. On the other hand, there were two other relevant concerns. One was the need to train more people faster, and the second was the high cost per student for this type of intensive experience. Therefore, for one year, the program was modified

to a three-day-a-week schedule (Appendix A) with the total group meeting on one day and each subgroup meeting on one of the other days. While this enabled the staff to increase the size of the class from 14 trainees up to 20-24 trainees (with subgroups of 10-12), it did seem to reduce the feeling of group compatibility in the training experience. Trainees felt able to relate comfortably to their own small subgroup but experienced some inhibitions when meeting with the whole group. Increased numbers also provided some difficulties in terms of supervision and conferences between trainees and staff members. Another question that arose concerning the larger group was "how diversified can a group be both in experience and interest and still participate together in a way that will provide satisfaction for a majority of the trainees a majority of the time?" It was not uncommon for one student to say that the morning presentation was really dull and another to describe that presentation as the most exciting part of the program. However, the overall evaluation of these groups as compared with other groups show this approach as a feasible option.

Somewhat reluctantly, the staff designed a summer program because there had been so many requests from individuals from out of the area who were able only to participate in a summer workshop. The basic 11 week program was converted into a 5-day-a-week, four-week program (see Appendix A).

The overall impression of the staff was that for some individuals this intensive workshop was the format of choice. Trainees became immersed in the total experience, as opposed to half-time in the program and half-time in a field agency. However, some people did experience a good deal of difficulty with the integration of this tremendous amount of input. The staff would recommend that either format be used, depending on the realities

of the work situation, but that selection of trainees be carefully done with respect to the applicant's internal timetable.

Participants

Several factors guided the selection of trainees. All applicants must have been involved in the delivery of some kind of human service to the community. The group was co-educational and interdisciplinary. But all of the women accepted were nurses with preference given to those with a graduate degree who were engaged in the fields of public health, psychiatric nursing or community mental health nursing.

It was a challenge to choose a group of compatible individuals whose behavior would be reciprocally growth-producing. No simple formula or format has been devised. However, the selection process went generally along these lines:

-Receipt of application with relevant personal and professional history;

-Determination of eligibility;

1. U.S. citizenship or equivalent
2. Completion of basic course of professional education (with preference given to graduate education)
3. Adequate life experience and demonstration of ability to cope successfully

-Request for two recent clinical or work references;

-A personal interview with individuals from the area or a taped interview with follow-up phone calls for out-of-area people;

-Presentation of the application to the selection committee.

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Selection was then made on a "first-come" basis but with respect to the heterogeneous group composition in relation to sex, race, personality and discipline. Several authors have emphasized the need for interdisciplinary learning experiences in order that individuals can improve their own education, better understand other professionals, and ultimately improve patient care or client service (Zander, 1957; McGarvey, 1966; Pellegrino, 1966; Reader, 1967; Duncan and Kempe, 1968; and Magraw, 1968).

A major responsibility of the staff was addressing themselves to the question "what is the fit between what the program has to offer and what the applicant is seeking?" As indicated earlier in the discussion about the brochure, it is very difficult to describe a process program in words that all individuals will interpret in the same manner. What an applicant was seeking was influenced not only by his understanding of the brochure, but also by his expectations of MRI itself. One applicant came back for a second interview and told about some of her reactions to the first interview. She didn't remember hearing the interviewer's name (she somehow missed the introduction) and as she tried to make sense of it later, she told herself that this was probably part of the planned interview situation and the test was to see if the applicant would take the intiative in asking the interviewer for identification. This kind of making sense or attributing characteristics to the agency was apparent in another incident that occurred. One of the trainees on the first day exhibited rather non-conforming behavior. On the second day, this was commented on, and it was apparent that a good number of the group of 14 students had been upset by this behavior. In fact, one trainee had described Student "X" to her husband and her husband, who was a trained social worker, had said, "Well, knowing MRI, this

individual is probably a plant to see what the group will do in this kind of a situation."

Another question to be considered was "Why would an individual be willing to travel 2,000 miles or more for the CHS training program?" It became apparent that some of the more traditional types of screening devices such as reference letters were not really that helpful. Nor was the matter of academic preparation necessarily relevant. It was more a matter of selecting an individual whose past experiences had prepared him for the kind of laboratory program that the CHS course provided.

Likewise, the major question or concern in relation to the kind of laboratory group experience offered by the CHS program was, "What are people looking for when they apply for this program?" "Is it a question of growth, is it a question of learning, or is it a question of therapy? And, where is the dividing line? How do you screen out those individuals who could more fittingly use an actual therapeutic situation?" What the interviewer tried to determine was the level of pain of the the applicant. That is, was the individual motivated by a real inability to perform and really looking for therapy; or was the individual motivated by the desire to see what kinds of alternative behaviors could be discovered in a group learning experience?

It was somewhat easier to deal with the question and find an answer when individuals lived in the geographic area and could come in for a personal interview. It proved helpful to utilize a structured interview--that is, asking each applicant a series of pre-determined questions (see Appendix E). These questions were aimed at the process the individual would utilize in answering the questions--not specifically at right or wrong kinds of answers. For example, to the question, "What is your primary sexual orientation?", the interviewer was looking more for the

comfort an individual had in relation to the question or to his decision about how to answer. The interview was purposely set up to be a sample of the course that was to come--i.e., the interview itself was experienced by most of the applicants as being both hard work and a rather stressful experience. Notes were taken during each interview (with the permission of the applicant) which were later evaluated in light of the guidelines in Appendix E.

Applicants who were not able to come in for a personal interview were sent an audio-tape with the set of questions. They were asked to have a friend interview them and tape-record the session. It appeared that for some individuals, receiving the structured interview questions served as a screening criterion. Some were never heard from again, and others sent the tape back with comments such as "I decided that this program doesn't fit for me."

Some of the factors relevant to selection of participants have been discussed. To summarize, Stock (1964) has suggested that in setting up a group laboratory experience, members should be homogeneous in characteristics such as intellegence, job competency, and emotional stability; but members should be heterogeneous with respect to age, sex, personality and occupation.

EVALUATION DESIGN

So far in the presentation of this case history of a group learning experience for graduate health professionals, the focus has been on the sequence and process of organizing and implementing the specially designed CHS program. Equally important is a consideration of the degree of effectiveness of the program.

The following section will discuss the evaluation design as it evolved

during the duration of the experience.

EVALUATION: THE PILOT GROUP PHASE

Two groups constituted the pilot population. Group One was scheduled during January, February and March of 1968 while Group Two followed in April, May and June. The evaluation design (Table 3) utilized instruments which were designed to tap four domains: 1) content, 2) interpersonal perception, 3) group process and 4) the total program. In order to do justice to the richness of the special CHS program, the assessment strategy had to be multi-faceted. The sequential-group, pre-test, post-test, quasi-experimental design was selected to accomplish this goal.

Instruments

A major goal of the program was to impart to the trainees a systems-oriented understanding of individual, group and family behavior. If successful, this orientation would be manifested both in a trainee's perception of a unit of behavior as well as a grasp of concepts used to describe inter-personal systems.

Three content instruments were used. A multiple-choice quiz on the didactic presentations of communication theory and human systems theory was given first at the beginning of the program and then again at the completion of the program. This quiz was constructed by the CHS staff.

Second, each trainee was furnished with both an audio-tape and a type script of three segments of group interaction and asked to do a written analysis of the material. The responses were scored on one dimension of the Film Rating Scale[4] after the pre and post protocols had been scrambled.

TABLE 3

Evaluation Design

PILOT PHASE

	GROUP I INTERACTION ANALYSIS	GROUP II INTERACTION ANALYSIS
CONTENT	QUIZ (FORM I) CRITICAL INCIDENT (FORM I)	QUIZ (FORM I) CRITICAL INCIDENT (FORM II)
INTERPERSONAL PERCEPTION	BI-POLAR SCALES GENERAL ATTRACTION- GROUP SCALES (FORM I)	BI-POLAR SCALES GENERAL ATTRACTION- GROUP SCALES (FORM I)
GROUP PROCESS	MEYER-BRIGGS TYPE INDICATOR	MEYER-BRIGGS TYPE INDICATOR
TOTAL PROGRAM	RETROSPECTIVE EVALUATION QUESTIONNAIRE (FORM I) INDIVIDUAL INTERVIEW	RETROSPECTIVE EVALUATION QUESTIONNAIRE (FORM I) GROUP EVALUATION

Utilizing the Critical Incident technique (Flanagan, 1954) as a model, forms were developed on which students would recount pairs of effective and ineffective learning experiences. Each student completed six sets during the program.

Two interpersonal perception instruments were used. Bi-Polar Scales were devised to allow comparisons to be made between 'Self' and 'Ideal Self' amd between 'Self' and 'Self-as-percieved by the Group'. These scales were administered on a pre-post course basis.

Also, general Attraction Scales (which yielded perceptual scores, apparency scores, and attractiveness scores for each trainee) were given bi-weekly.

One group process instrument was used. The Meyer-Briggs Type Indicator was given at the beginning and at the end of the course to categorize trainees along four dimensions derived from Jungian theory. These dimensions are as follows:

(1)	Extroversion vs. Introversion	(E vs. I)
(2)	Intuition vs. Sensing	(S vs. N)
(3)	Thinking vs. Feeling	(T vs. F)
(4)	Judgement vs. Perception	(J vs. P)

Two total program instruments were used at the end of the course. One was an individual tape recorded evaluation interview. The other was a Retrospective Evaluation Questionnaire (Form I).

Results

Twenty-two individuals participated in the Pilot Phase - nine in Group 1 and thirteen in Group 2 (Table 4).

The content oriented instruments yielded the following information.

The Communication and Human Systems Quiz indicated that both groups had more knowledge of the substantive material at the end of the course

TABLE 4

Demographic Data - Pilot Groups I and II

	Student	Age	Sex	Degree	Specialty
One Group	A1	28	F	BS, MS	Psychiatric Nursing
	A2	40	F	BS	Public Health
	A3	41	F	BS, Med.	School Health
	A4	44	F	Diploma	Psychiatric Nursing
	A5	50	F	Diploma	Nursing Science
	A6	25	M	MA	Group Psychology
	A7	25	M	BA	Theology Student
	A8	33	M	BA, MBA, BD	Theology
	A9	35	M	Ph. D.	Psychology
Two Group	B1	24	F	BS	Psychiatric Nursing
	B2	28	F	BS	Psychiatric Nursing
	B3	34	F	BA	Mental Health Nursing
	B4	34	F	BS	Nursing Research
	B5	34	F	BS	Public Health Nursing
	B6	35	F	BS	Public Health Nursing
	B7	40	F	BA, BS	Psychiatric Nursing
	B8	26	M	BA	Group Psychology
	B9	32	M	BA	Penology
	B10	34	M	AA	Business Administration
	B11	35	M	BA	Penology
	B12	46	M	Ph. D.	Psychology
	B13	59	M	BA	Industrial Training

than at the beginning of the course. Pooled data from both courses revealed 17 gains and 1 loss, with 1 remaining the same; these gains are significant ($p = <.001$ level, Sign Test). Moreover, the gain shown by members of each class was significant ($p = <.002$ and $p = <.02$ respectively; Sign Test).

The scores of both quizzes had a considerable range, the higher scores being obtained by trainees whose academic experience was ongoing or quite recent. Thus, motivation and set, as mediated by current or recent extramural experiences, may have affected the results.

A seond approach to the evaluation of assimilated content was to score the trainee's approach to the understanding of some interpersonal situations on tapes and typescripts. This analysis revealed an increase in the use of language reflecting transactional conceptualization of the interaction, accompanied by a decrease in predominately intrapsychic language. In addition, the mean number of responses decreased from 44.12 to 30.86. Discussion with trainees suggest that this may be due to greater impatience with evaluation instruments by the end of the course and/or to increased skill in being concise.[5]

Several conclusions may be drawn from the Critical Incident forms which were developed to describe both effective and ineffective learning experiences. It would seem that the majority of effective incidents took place during laboratory sessions involving interaction among several people. These experiences did not necessarily involve feedback about self, but there was usually active participation by the trainee, as opposed to passive participation. The ineffective incidents described were consistent with the above conclusions. Most of the ineffective incidents occurred in the "classroom" when activities were too didactic or not involving enough. The Critical Incident forms proved difficult to analyze and from

feedback discussions with the trainees it was found that they contributed less to the learning experience than had been hoped.

The results from the Interpersonal Perception instruments were also disappointing. The Bi-Polar Scales, devised to allow for comparisons to be made between Self and Ideal Self and between Self and Self-as-perceived-by-the-group, failed to show significant changes over time, even for the pooled data. However, the tendency in each class was for a decrease in the discrepancy between the conceptualization of one's self and of one's ideal self.

The General Attraction Scales showed a gain in perceptual accuracy, indeterminate fluctuations in apparency, and a fairly stable gain in intra-group attraction; only the scores for the last variable showed stability over time in the sense that wild fluctuations were not in evidence.

In relation to group process, the scores from the Meyers-Briggs Type Indicator were utilized in derviving a predictor variable which correlated .90 with the individual trainees' average attraction ranks over the six sessions in which the General Attraction Scales were administered. The first class was composed mainly of people who were relatively high on extroversion (versus introversion), intuition (versus sensing), feeling (versus thinking), and perception (versus judgement). Trainee attractiveness was correlated .64 with judgement-perception, which had a predominantly perceptual rather than judgemental orientation.

As far as evaluation of the total program was concerned, much of the data obtained from the individual interviews was a repetition of material elicited in group discussions or on Critical Incident Reports. On the Retrospective Evaluation Questionnaire, the overall rating by Group One was somewhat higher than for Group Two. The majority of students in both groups used descriptive phrases such as "one of the most meaningful

of my life experiences".

Recommendations and Modifications

On the basis of the experience with the pilot phase, it appeared that many of the instruments were too unwieldly and not very productive. Therefore it was decided to spend the summer break time in completely revamping the design. The following goals were set for the revised evaluation program: 1) detailed trainee orientation to the evaluation purposes, instruments, and schedule; 2) increased tailoring of the instruments to the course goals; 3) increased efforts to design and use the instruments in ways which will make them valuable as part of the learning experience; 4) revision of instruments to increase their palatability; 5) increased opportunities for two-way feedback; and 6) increased participation of the evaluation staff in the teaching facets of the course.

EVALUATION: STUDY GROUPS PHASE

After the pilot phase of the Communication and Human Systems Program, the approach to program evaluation (with subsequent implications for program modification) was redirected. Initially, the evaluation design was a replica of the traditional goa-attainment model: "evaluation as a measurement of the degree of success or failure encountered by the program in reaching predetermined objectives (Schulberg and Baker, 1968, p. 1250)".

The continuing educational focus on system theory fostered an increased awareness of the value of applying this kind of orientation to the evaluation aspect of the Communication and Human Systems Program. Efforts were then directed toward modifying the program in the direction of the system

model: ongoing evaluation of "the degree to which the project realizes its goals under a given set of conditions" with regulated feedback being assimilated by the system (Schulberg and Baker, 1968, p. 1253)".

The Evaluation Design for the Study Phase of the program was constructed to yield both quantitative and qualitative data (Table 5). The quantitative measures (Appendix F) were those which focused on measuring change in the trainees' self-concept (both personal and professional) and in relationships with others, especially in the work situation. The battery of instruments included: 1) Inventory of Uniqueness (IOU), 2) Remote Associates Test (RAT), 3) Semantic Differential, and 4) Berger Self-Other Acceptance Scale. All of these evaluation instruments were given on a pre-post basis, i.e., they were administered at the beginning and again at the end of each CHS course. Change scores for these two administrations were obtained and analyzed using Wilcoxon (1947) matched-pairs, signed-rank, non-parametric statistic test. In addition, the Retrospective Evaluation Questionnaire (REQ) was administered once, at the completion of the program. The Statistical Package for the Social Sciences (SPSS) is the computer program that was chosen since it is an integrated system designed especially for the analysis of social science data (Nie et al, 1970).

The qualitative data was garnered from field notes and diaries, tape recorded evaluation sessions, and follow-up questionnaires and interviews.

QUANTITATIVE MEASURES

Inventory of Uniqueness

For the pilot groups, a Q-sort measure of self and ideal self was used (after Rogers and Symond). The limitation of the forced-sort technique

TABLE 5

Evaluation Design - Study Phase

DIMENSION	INSTRUMENT	ADMINISTRATION Basic Program Pre	Post	TREATMENT
Perceived Self	Inventory of Uniqueness	Time 1	Time 2	Change Scores Correlations
Self-Esteem	Inventory of Uniqueness	Time 1	Time 2	Change Scores Correlations
Self-Actualization (Creativity)	Remote Associates Test	Time 1	Time 2	Change Scores Correlations
Professional Self-Acceptance	Semantic Differential	Time 1	Time 2	Change Scores Correlations
Self-Acceptance Other-Acceptance	Berger Scale	Time 1	Time 2	Change Scores Correlations
Overview	Retrospective Evaluation Questionnaire	Final Evaluation		Item Analysis
Process of Program Participation	Field Notes and Diaries	Ongoing Recording		Content Analysis
Occupational and Personal Effectiveness	Follow-up Questionnaire	Interviews		Content Analysis

was that there was no way of knowing how representative the presented items were of the individual's phenomenal self (Wylie, 1961). Consequently, an Inventory of Uniqueness (IOU) was especially designed to implement the stated goal of increasing the trainees' understanding of their own uniqueness. This instrument asked the trainees to write a number of statements about themselves (originally 25 statements for Group Three but changed to 20 statements for subsequent groups), and to rate these statements in terms of how important they felt they were presently and how important they would wish them to be (Self: Ideal-Self discrepancy). The trainees were also asked to indicate if they felt positively or negatively about these statements.

The second administration of this instrument consisted of returning to the trainee his orginial 20 statements in randomized order with instructions that he rate them again in terms of "how important they are now" and "how important he would wish them to be".

While Wylie (1961) points out that this type of R-R (response-response) technique cannot support unequivocal cause-effect inferences, she does concede this approach is necessary for certain phenomenological propostions and also reports that the self-esteem factor can yield fruitful research data.

A discrepancy score between "how important each statement is now" and "how important you would wish each statement to be" was computed and the scores for Time 1 and Time 2 compared, using the Wilcoxon signed-ranks test. It was expected that the discrepancy scores would decrease over the course of time.

As a beginning exploration to determine if there was a sequential process in the development of the self-concept, self-other scores were compared with self-esteem scores by using a standardized correlation measure.

The Remote Associates Test

Since self-actualization is defined as the ability to express individuality and originality, one significant measure of this factor would be a test of creativity. There is increasing interest in the question "what constitutes and/or fosters creativity?" (Bingham, 1953; MacKinnon, 1962; Bailey, 1970). Of particular interest are the findings that word association tests are the best predictors of creativity, and that there is a linkage between self-acceptance, self-esteem, and creativity.

The Remote Associates Test (RAT) is a standardized test of creativity (Mednick and Mednick, 1967). In form it is a word association test but it takes its title "Remote" from the fact that the stimulus words were originally the remote responses to the standard word association tests, i.e., they were responses given .1% - .3% of the time to the usual stimulus words. There are 30 stimulus triads on each form of the RAT and there are two forms which were administered.

The RAT, which was expected to assess the ability of the trainees to connect ideas, or to be creative was administered both before and after the total group experience. These group laboratories were designed in part to be a "freeing-up" process. The literature on the use of this instrument reports it to be a highly reliable one over time. Most people attain the same score on administration of the two forms of the instrument. The hypothesis was that there would be an increase in scores from Time 1 to Time 2 because of the "freeing-up" process of the group experience.

Again, in an effort to determine if there was a sequential process in the development of the self-concept, self-esteem scores and self-actualization (creativity) scores were compared.

Semantic Differential

A Semantic Differential instrument (Osgood et al, 1957) was designed

to assess the impact of the training experience on the trainees' professional self-acceptance. It focused on the following concepts: 1) Self; 2) Self as a professional; 3) Supervisor/ Self Relationship; 4) Self/ Patient Relationship; 5) Profession; 6) Women; and 7) Men. Because most professional training, especially for nurses, takes place with members of the same sex only, it was desirable to assess the unique coeducational aspect of the CHS program. Therefore, the concepts of Women and Men were also included. The trainees rated each of these seven concepts in terms of twelve adjective-pair scales (e.g., hot-cold, good-bad, active-passive) by placing an "X" in one of seven blanks that separated each adjective pair (Likert, 1932), with "1" being the negative end and "7" being the positive end and "4" being the neutral or mid-point. Scores for Time 1 and Time 2 were computed and a change score calculated using the Wilcoxon signed-ranks test.

This instrument was relatively easy to modify or "personalize" for each student. It is also uncomplicated to administer and score and yet yields data that is considered reliable and valid.

Berger Scales

The Berger Attitude Scale (Berger, 1952, 1955) is a standardized instrument which measures a person's acceptance of self and acceptance of others. It was devised by Emanuel Berger and is reported in the literature to be a reliable and valid measure of self and other acceptance. This instrument asked each trainee to assess 64 statements in terms of the following Likert-type scale: 1) not at all true of myself; 2) slightly true of myself; 3) about half-way true of myself; 4) mostly true of myself; and 5) true of myself. Of these 64 statements, 36 are statements of attitudes of acceptance of self and 28 are statements of attitudes about acceptance of others. Since Sheerer (1949), Stock (1944), Omwake

(1954), and Shaw and Wright (1967) have reported positive correlations between self and other acceptance, the same results were expected in this study.

The Retrospective Evaluation Questionnaire

The Retrospective Evaluation Questionnaire (REQ) was administered on the last day of each course just prior to graduation. This questionnaire asked the trainees to rate each component, i.e., Didactic, Dynamic, Encounter, Field Work, and Evaluation on a series of statements, e.g., "The Instructor(s) Spoke Clearly", "The Instructor(s) Treated the Trainees with Respect", "The Instructor(s) Gave Feedback to the Trainees". These statements were rated on a 10 point scale. There were also some questions concerning the over-all impact of the course, e.g., "the course fulfilled its stated goals", "the course was relevant to your personal situations, problems and goals", "your over-all evaluation of the instructors".

In the final year of the program a Follow-up Questionnaire was sent to all 167 graduates. The elapsed time since completion of the program varied from 5 to 24 months. The questionnaire (Appendix F) which yielded both qualitative and quantitative data, was designed to tap three informational areas: 1) demographic data, 2) trainee assessment of program and staff, and 3) trainee self-reports of effects of program both personally and professionaly.

The demographic data were punched on computer cards. The open-ended items were handled in two ways. First, an independent researcher (not familiar with the program) reviewed the questionnaires, developed a code of significance and tabulated the items accordingly. These tabulations were then converted into a statistical package that consisted of frequency distributions for 83 variables. These 83 variables plus 12 variables from the pre-post test package were cross-tabulated for

significant relationships using the Chi Square.

In addition to the evaluation instruments described above, two other standardized tests were administered to some of the training groups.

Self-Disclosure Questionnaire

A Self-Disclosure Questionnaire (Jourad, 1964) was given to groups #3, #4 and #5. This instrument was designed to assess the "openness" profile of each trainee and to show changes over the period of the course in regard to disclosure about various topics (e.g., personality, childhood family, and work) to a variety of significant targets (i.e., closest other, CHS group, work supervisor, work peer, and work supervisee). It was hypothecated that there would be an increase in reported self-disclosure scores across all five targets from Time 1 to Time 2 because of the priority placed on "openness" in the group experiences. However, because of the vagueness of the data generated coupled with the negative feelings of staff and trainees about the complexities and time-consuming nature of the instrument, it was dropped from the test battery.

The FIRO-B Instrument

The FIRO-B instrument (Schutz, 1966, 1967) was administered to Groups #6, #7 and #8, on a pre-post basis. This instrument is widely used in assessing group changes over time in the interpersonal need areas of affection, inclusion, and control. The results of CHS use of the FIRO-B instrument showed no changes for any of the three groups on the FIRO-B categories. In fact, its use in the group context tended to reduce the data to the mid-score on all 6 need areas. Because of these findings and the belief that the FIRO-B instrument seems to have more validity in a clinical context, it was dropped from the battery of evaluation instruments.

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QUALITATIVE MEASURES

In order to have some measure of the individual and group process of each program, the trainees were asked to keep field records and diaries. A systematic method of coding and analyzing such subjective, qualitative data is called content analysis by Berelson and theory generation by Glaser and Strauss. Kerlinger (1964) cautions that this method of analysis should not be used indiscriminately as it is both laborious and time-consuming. However, he goes on to say there is also a logic and economy about using this method of observation. "Instead of observing people's behavior directly...the investigator takes the communications that people have produced and asks questions of the communications (p. 544)."

Field Notes

The field notes (which reported on a project in an actual setting) were used as a basis for discussion and supervision with a staff member. In addition, they were coded and analyzed for data related to the process of change or growth. Sarbin and Allen (1968) point out that little research has attempted to penetrate the process of acquisition of roles ...and in the usual laboratory studies the individual is viewed as a passive organism, in contrast to the active organism who acquires roles in real life situations (p. 544).

Diaries

The diaries were a personal account of how the individual saw himself in relation to the CHS group experience. Based on the assumption that all behavior has meaning when viewed in its total context, trainees were asked to report what was "freely recalled" as they reviewed the day or week. Notations were collected on a weekly basis.

The coding and analysis of the field notes and diaries (Glaser and

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Strauss, 1967) were expected to yield profiles of the change process in its specific as well as its general range. For example, was the configuration of the Communication and Human Systems program like one of the equilibrium models of Bales, Lewin or Bion? Did it compare to the six phases of Bennis and Shepard or the four stages of Geller?

Interview

As indicated earlier, in order to have some evaluation over time, a carefully constructed questionnaire was mailed to all Communication and Human Systems Training Program graduates. The areas of investigation included the Training Program format, occupational effectiveness evaluation, system modification success, and general comments (Baird, 1969).

Kerlinger (1964) suggests that the mailed questionnaire (or self-administered interview schedule) is more effective when used in conjunction with other techniques. Accordingly, random interviews were scheduled (face-to-face or by telephone) with graduates, significant others in the graduate's work setting, and members of the Communication and Human Systems Training Program staff.

SUMMARY

The problem is to determine the effect on the self-concept of participation of graduate health professionals in a group laboratory experience focusing on communication theory and human system theory. First the design of the program itself was reviewed. This was followed by a discussion of the selection of the quantitative and the qualitative tools that make up the evaluation design.

CHAPTER FOUR - PROGRAM OUTCOMES: QUANTITATIVE DATA

The data generated by this study of the effect on the self-concept of participation by graduate health professionals in a structured group laboratory experience focusing on communications theory and human system theory will be presented in two chapters. Chapter Four will report all of the quantitative data and Chapter Five will review the qualitative data.

Twelve groups of individuals were trained during the lifetime of the CHS program. One hundred seventy five individuals who applied for CHS training were accepted. Of these, 90 were women and 85 were men. Of the 90 women, 57 came from California and 33 from out of the state. Of the 85 men, 67 came from California and 18 from out of the state (including one from Canada and one from Australia). The age range of the trainee groups was from 23 to 65 years. Table 6 illustrates the age distribution. Groups One and Two constituted the pilot group and have been described in Chapter Three. Data relevant to the ten remaining groups, Groups Three through Twelve, will be reported here.

TABLE 6 - AGE DISTRIBUTION OF CHS TRAINEES

AGE RANGE	ABSOLUTE FREQUENCY	ADJUSTED PERCENT
20 - 24	10	5.7
25 - 29	37	21.1
30 - 34	36	20.6
35 - 39	32	18.3
40 - 44	21	12.0
45 - 49	23	13.1
50 - 54	10	5.7
55 - 59	4	2.3
60+	2	1.1

PROGRAM PARTICIPANTS

There were 153 trainees in the study group population (for individual demographic data see Appendix G). Of this number 77 were women and 76 were men. Of the women 45 came from California and 33 from out of state, while 57 men were from California and 18 from out of state.

Table 7 indicates some of the demographic characteristics of Groups Three through Twelve.

TABLE 7

Group Demographic Characteristics

DATE	GROUP	N	M	F	GROUP AGE RANGE	AGE SPAN
Sept. '68	Group 3	12	6	6	23 - 60	37
Jan. '69	Group 4	14	7	7	25 - 50	25
April '69	Group 5	14	7	7	25 - 49	24
Sept. '69	Group 6	20	10	10	25 - 65	40
Jan. '70	Group 7	18	9	9	24 - 55	31
April '70	Group 8	20	10	10	23 - 54	31
Sept. '70	Group 9	13	7	6	23 - 51	28
Jan. '71	Group 10	14	7	7	26 - 50	24
April '71	Group 11	14	7	7	23 - 46	23
June '71	Group 12	14	7	7	23 - 55	32

While selection criteria were established to foster heterogenous groupings, the fact that the program was designed for graduate health professionals distinguished the trainees from a standard population. Fifteen women and thirty men had bachelors degrees. Fifty-four women and twenty-one men had masters degrees, while seventeen trainees had done post-masters work (two women and fifteen men). In addition, two

women and six men had doctoral degrees.

EVALUATION INSTRUMENTS

The evaluation packet included the Remote Associate Test, the Inventory of Uniqueness, the Semantic Differential and the Berger Self-Other Acceptance Scale, all of which were administered on a pre-post basis. This administration yielded individual scores and change scores as well as group scores and change scores.

The Inventory of Uniqueness (IOU) was designed to yield information about an individual's degree of self-acceptance through the "Positive Feelings of Self" score as well as a measure of self-esteem through the Self/Ideal discrepancy score. Figure 1 shows the general trend toward an increase in percent positive feelings about self at Time 2. Figure 2 illustrates that every group except 5 also showed an increase in self-ideal self correlation scores between the pre and post testing. For Groups 6 - 12 this increase in correlation score was significant at the $<.05$ level using the Wilcoxon Test (Table 8).

The Remote Associate Test (RAT) was chosen as an indicator of self-actualization or creativity. Because of the documentation that it is a reliable instrument over time, the CHS experience appears significant. Figure 3 shows that there was a consistent pattern for each group of an increase of the post-test mean over the pre-test mean. In addition, Table 8 indicates that the comparison of individual pre-post scores using the Wilcoxon Test was significant at the $<.05$ level for eight of ten groups.[6]

The seven concept factors of the Semantic Differential (S.D.) were included in order to have a measure of attitude change regarding

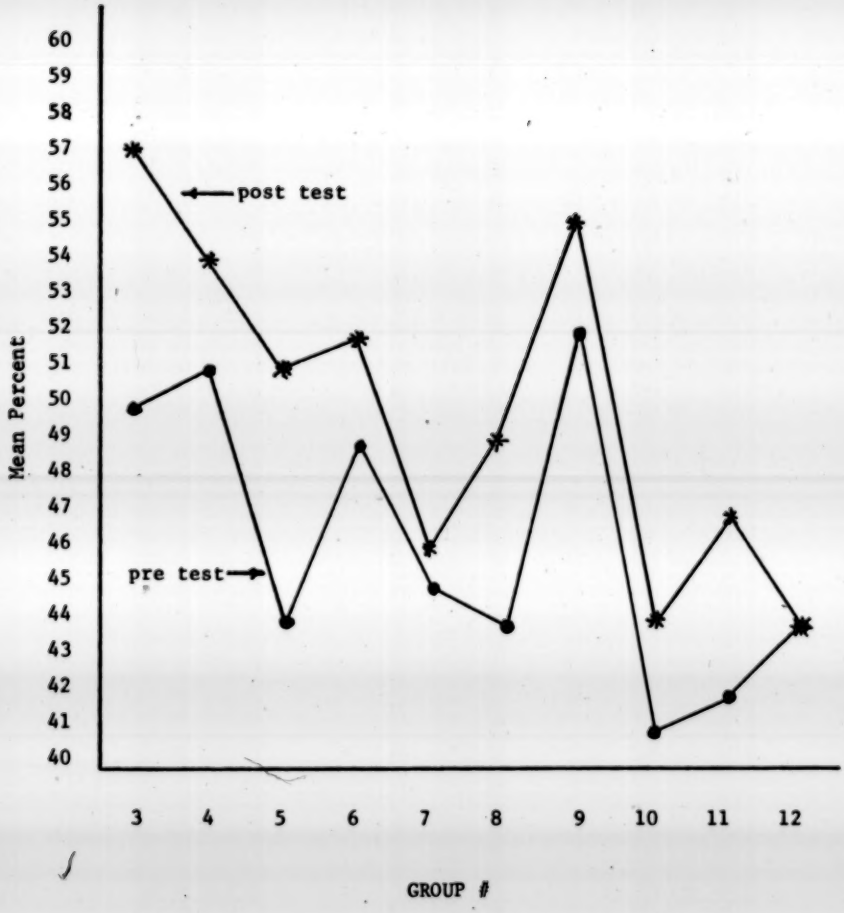


Fig. 1. Inventory of Uniqueness: Percent of Positive Feelings About Self - Group Scores: Pre and Post

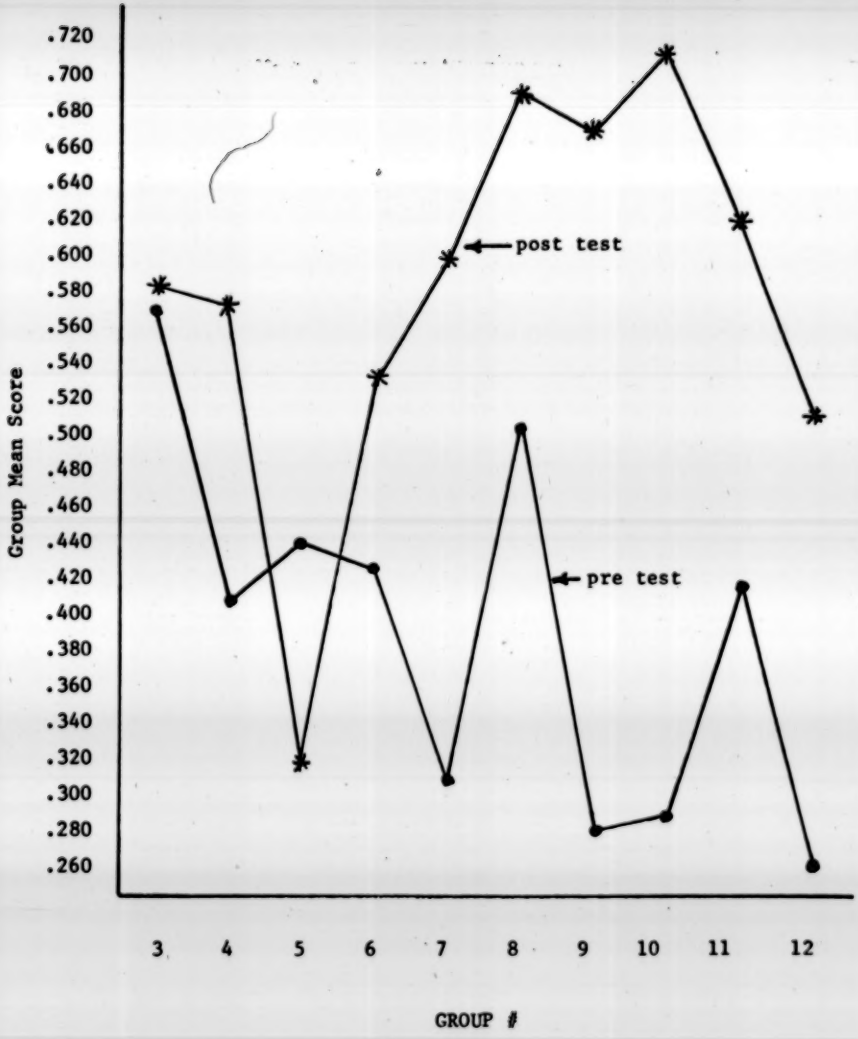


Fig. 2. Inventory of Uniqueness: Self/Ideal-Self Correlation Scores: Pre and Post

TABLE 8
Critical Values of The Wilcoxon T
Level of Significance for Two-Tailed Test

Group	Factors	I O U Self/Ideal	R A T	S.D.-S/Prof.	S.D.-Prof.	S.D.-Women	S.D.-Men	S.D.-Self	S.D.-S/Sup.	S.D.-S/Pt.
3	Test N	10	12							
	T Score	20.0	13.5							
	P	N S	.05							
4	Test N	14	12	14	14	14	14			
	T Score	35.0	7.5	26.0	36.0	29.0	42.0			
	P	N S	.02	N S	N S	N S	N S			
5	Test N	13	13	13	13	13	13			
	T Score	26.0	4.5	25.0	28.0	34.0	36.0			
	P	N S	.01	N S	N S	N S	N S			
6	Test N	19	19	19	19	19	19	19	19	19
	T Score	36.0	46.0	73.5	91.5	70.5	68.5	77.0	94.5	72.5
	P	.02	.05	N S	N S	N S	N S	N S	N S	N S
7	Test N	17	17	17	17	17	17	14	17	17
	T Score	23.0	33.5	18.5	16.5	29.0	35.0	20.0	59.0	35.0
	P	.01	.05	.01	.01	.05	.05	.05	N S	.05
8	Test N	20	19	20	20	20	20	20	20	20
	T Score	32.0	57.5	33.0	66.5	30.5	37.5	36.0	44.0	30.0
	P	.01	N S	.01	N S	.01	.01	.01	.02	.01
9	Test N	13	12	13	13	13	13	13	13	13
	T Score	7.0	3.5	41.0	16.0	38.0	16.0	20.0	28.0	23.5
	P	.01	.01	N S	.05	N S	.05	N S	N S	N S
10	Test N	14	14	14	14	14	14	14	14	14
	T Score	7.0	18.0	28.0	41.0	36.0	21.0	21.0	42.0	36.0
	P	.01	.05	N S	N S	N S	.05	.05	N S	N S
11	Test N	13	13	13	13	13	13	13	13	13
	T Score	6.0	15.5	21.0	22.5	28.5	23.5	17.0	31.0	22.0
	P	.01	.05	N S	N S	N S	N S	.05	N S	N S
12	Test N	14	12	14	14	14	14	14	14	14
	T Score	21.0	38.0	21.0	33.5	34.5	13.0	19.5	35.5	21.0
	P	.05	N S	.05	N S	N S	.01	.05	N S	.05

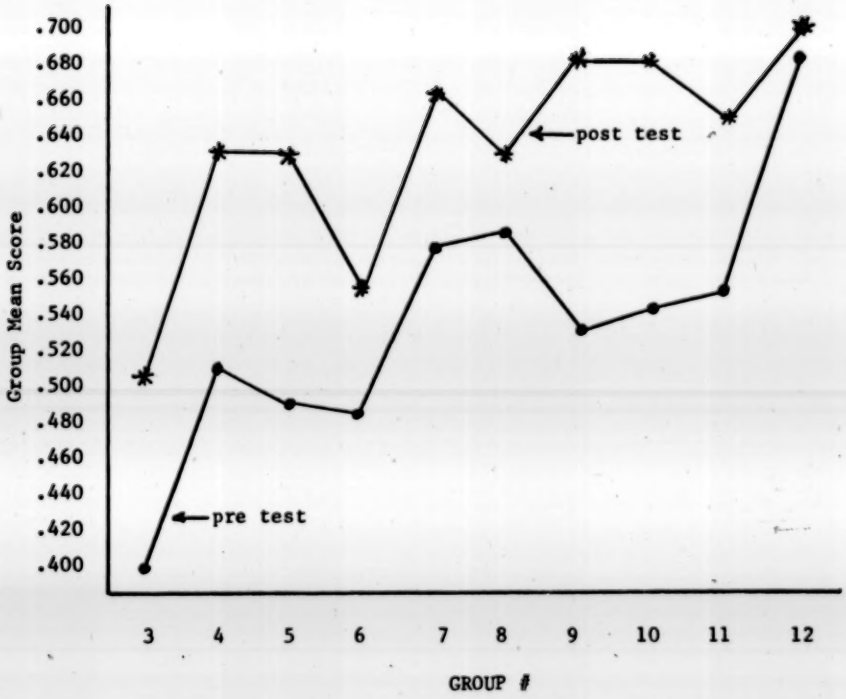


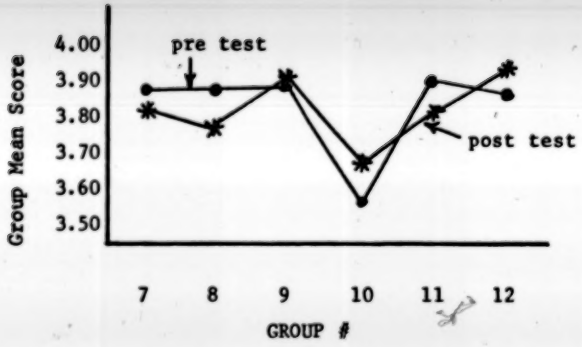
Fig. 3. Remote Associate Test: Group Mean: Pre and Post

self-acceptance and professional self-acceptance. The data from this instrument does not support the expectation of consistent change in the direction of greater acceptance. Of the fifty seven concept measures obtained from Groups 4 - 12, levels of significance were reached in only twenty one of these (Table 8). Groups 7 and 8 showed significance at the $<.05$ level for six of the seven concepts. Across groups, significant scores were achieved for half the groups on acceptance of men and acceptance of self.

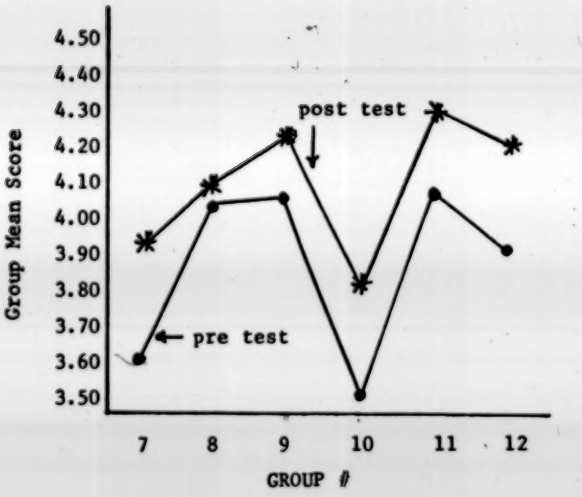
It had been expected that the importance of the unique co-educational aspect of the program would be reflected in significant score increases for the two concepts "women" and "men". Though this expectation did not materialize, the assumed value of heterogenous grouping was substantiated by staff observations and trainee comments.

The Berger Attitude Scales also yielded mixed results. Figure 4 shows the pattern of an increase in self-acceptance scores for each group at Time 2 administration as was predicted. However, the prediction of a positive correlation between self-acceptance and other acceptance has not materialized.

A Retrospective Evaluation Questionnaire (REQ) was administered to each group. Table 9 shows the mean scores (derived from 0-10 rating scale) for groups 3 - 12 in regard to the six CHS program components. The mean scores for each component exceed the expected measure of central tendency, the range being from 5.26 to 9.82. Especially significant is the range of the "Overall" component (7.86 - 9.82).



Other - Acceptance Scores



Self - Acceptance Scores

Fig. 4. Berger Self - Acceptance and Other - Acceptance Group Mean Scores: Pre and Post

TABLE 9

Retrospective Evaluation Questionnaire

Mean Scores

The Six CHS Program Components

Group	Didactic	Dynamic	Encounter	Field Work	Evaluation	Overall
3	6.74	8.58	8.35	8.47	8.13	9.82
4	7.02	7.10	7.76	7.42	5.26	7.86
5	7.54	7.84	7.84	8.07	6.59	9.00
6	7.99	7.12	7.62	6.89	6.90	8.84
7	7.43	8.09	8.41	8.76	7.71	9.35
8	7.19	6.90	7.91	8.16	7.91	8.95
9	9.40	9.29	7.96	8.55	9.32	9.75
10	8.01	8.32	8.20	7.90	8.16	9.43
11	8.74	8.06	7.83	7.68	8.37	8.46
12	8.77	8.88	9.17	----*	8.35	9.77

*No field work offered during four week summer program

A follow-up questionnaire was mailed to each former trainee who could be located. Of the individuals contacted, 143 completed and returned the questionnaire. This return rate of 88% far exceeds the expected rate. According to Kerlinger (1964):

> Responses to mail questionnaires are generally poor. Returns of less than 40 or 50 percent are common. Higher percentages are rare. At best, the researcher must content himself with returns as low as 50 or 60 percent (p. 397).

The information from the questionnaires was coded, tabulated and card-punched in order to yield frequency tabulations. The comments which were made with enough consistency to appear to be significant are reported below.

In order to encourage individual, specific comments, one global, open-ended question was asked: 'Where are you now compared with where you were when you completed the CHS course; A. Personally? B. Professionally?'

Improved personal relationships were mentioned by 126 respondents. Of these, 60 or 42.3% reported a "little change" while 66 or 46.5% reported "marked change".

Marked improvement in work relationships was reported by 38 trainees: (26.8%) while 69 or 48.6% reported a slight change.

Being more open to new ideas was mentioned on a significant 87.3% (124) of returned questionnaires.

In relation to overall change or general improvement, 95 individuals (66.9%) reported some change and 40 or 28.2% reported important changes.

As a point of comparison the CHS staff was asked to rate the amount of change perceived for each trainee. They reported 8.5% as demonstrating no change, 17.6% who appeared little changed, 39.2% who appeared to have

changed moderately, and 29.5% who were seen as markedly changed.

When asked to critique the CHS program, 44.4% of the respondents offered no comments, and 34% made a variety of suggestions relevant to planning of future programs but which they regarded as minor. Only 22% of the respondents made comments about which they felt very strongly. The greatest number (8 or 5.6% of the respondent group) were distressed by signs of what they regarded as staff dissension. Six (4.2% felt there was too little actual work with families; four saw the staff as too remote; another four (2.8%) disliked the T-group experience; four more thought there was too much theory while three (2.1%) thought there was too little theory; and two respondents felt there was too much testing.

When the questionnaire data were analyzed using crosstabs and Chi Squares, the following relationships became evident (Table 10).

TABLE 10

Questionnaire Variables with Significant Relationships Using the Chi Square Test

	Variable One	Variable Two	Chi Square	D.F.	P
1	Amount of Change	Profession	11.16	3	.02
2	Rated Changed by Staff	Profession	12.11	5	.05
3	Rated Changed by Staff	Reported Change	18.50	9	.05
4	Change in Personal Relations	Highest Degree	10.13	2	.01
5	Change in Personal Relations	Change in Work	38.05	4	.001
6	Change in Work	Profession	7.05	2	.05
7	Change in Work	Sex	6.91	2	.05
8	Change in Work	Open to New Ideas	6.75	2	.05

In regard to Change and Rated Change, as demonstrated in examples one and two, nurses reported significantly more important changes than did other professionals and the staff also rated the nurses as demonstrating more marked changes than other professionals.

In example four, the higher the academic degree an individual possessed the greater the amount of change reported.

In examples six and seven, nurses and women reported significantly more marked changes in work relationships than did other professionals and men.

Crosstabs and Chi Squares were also computed for the basic evaluation package. This comparison indicated a correlation at the $\ell.05$ level for the IOU and Berger Scales. In other words, there is a significant relationship between self-esteem and self-acceptance and between self-esteem and other acceptance. A correlation at the $\ell.05$ level also exists between Berger-Self and Berger-Other. This finding is consistent with the expectation that an increase in the one score would be accompanied by an increase in the other score, though this did not materialize when comparing group mean scores.

When the seven factors of the Semantic Differential were compared using the Chi Square, more than half of them correlated at a significant level (Table 11).

While the Remote Associates Test just missed achieving a level of significance when compared with the other evaluation instruments, proportionately more of those who fell above the mean on the RAT, also fell above the mean on the other items.

Table 11

Cross Tabulation of the Seven Factors of the Semantic Differential Using the Chi Square Test

	Self	Self as Professional	Supervisor-Self	Patient-Self	Profession	Men	Women
Self	/	≤.001	≤.02	≤.01		≤.001	
Self as Professional	≤.001	/	≤.02	≤.001	≤.05	≤.01	
Supervisor-Self	≤.02	≤.02	/	≤.01	≤.05	≤.02	≤.01
Patient-Self	≤.01	≤.001	≤.01	/		≤.01	≤.10
Profession		≤.05			/		
Men	≤.001	≤.01	≤.02	≤.01		/	≤.001
Women			≤.01	≤.10		≤.001	/

CHAPTER FIVE - PROGRAM OUTCOMES: QUALITATIVE DATA

The tools that were incorporated into the design in order to illicit qualitative date (i.e., personal, process oriented information) were field notes and diaries which were written during the course and random interviews (face-to-face or by telephone) which were conducted after the completion of the training program. The informants were the trainees, their spouses or "significant others," and their work colleagues or supervisors.

DIARIES

The diaries were a personal account of each trainee's experiences in the group process of the CHS program and were therefore treated as a privileged communications tool. That is, the diaries were read only by the Director of the CHS program and the research associate. In line with the concept of choosing appropriate channels of communication, it was interesting to note that individuals did report different kinds of information in the diary from that which was reported or shared with the group as a whole. The diaries therefore provided the Director with another way to be in touch with "where trainees were at" so that, when appropriate, special individual conferences could be scheduled.

A wealth of material was contained in the diaries which were kept by 102 CHS participants from seven different groups. A sociological

organization of the information was accomplished through coding and analysis using the grounded theory approach (Glaser and Strauss, 1967). For description of the change processes in their specific and general ranges see the articles by Kathy Calkins (1972).

For this study a small but representative collection of comments has been included to convey an impression of the diversity of topic and range of intensity of the recordings.

When an individual has made a contract to be a contributing group member to the best of his or her ability, it often is not easy to decide how to follow-through on the decision, as the initial reactions of these nurses illustrates:

> Thoughts streamed through my mind--like what the hell am I going to say? I want to tell them about me but I'm scared. So I reverted to my objectives and offered little of myself personally.

> All day I was battling my ambivalent feelings about plunging in versus holding back...I kept me and my own reactions and feelings back. Why? Fear?

> I know I've been holding back in the groups...so much is going on underneath...I want to talk... don't know where to begin. But I'm not taking the responsibility myself and saying what I want.

The question of "when" to participate is soon followed by the question of "how" to participate. One man reported his first impressions of being a member of the group.

> This has thus far been quite an experience. I have felt stupid, sad, mixed-up, sorry, angry, defensive, argumentative, sadistic, self-pitying, inadequate...I have felt several times that I have failed miserably to put into words what my heart is feeling. In short, I am trying to "like" myself but can't find a real reason why I should. I want to fight back though and despise myself when I retreat.

Similarly, these women reported:

> I said a few things but I'm still feeling down about my lack of involvement. I guess the other thing that disturbs me is to be so aware of limiting myself because of fear of embarrassment.

> I spent the afternoon full of tears and anger and not able to do anything with either. It left me too preoccupied with me to be of any use to anyone else.

> I could not interpret for myself what other "group" members could. I was not motivated to participate. I'm not sure whether my inadequate feelings and low self-esteem was because of my rigid, self-centered and narrow-minded thinking pattern (my own personality) or my lack of adequate education and experience in this field.

> There seemed to be too much identification for any of us to be truly compassionate or truly helpful, lots of pity and self-pity.

One nurse reported, to her amusement, about the competition she observed in her group.

> It seems to me that some of the men can hardly contain themselves in their efforts to gain the attention of the group and then control of the group.

However, the struggles for "place" and leadership were not always humorous. A dramatic illustration of this is the comment of a man whose style had been questioned.

> I attempted to be open and not bring my weapons with me and put myself on the block and yet resisted and was raped in the process, not for my good but for the sake of need of completion--a need to reduce everyone to helpless tears, or something like that. A phony game on my part. I violated myself and allowed others to violate me and I want to draw some blood to fill the vacuum in me.

Another participant who competed for a top location and lost, stated "The experience is one of having a mask that no longer fits, but there is very little else".

When group tensions rise some members tend to avoid taking risks in the interactional arena feeling instead "Silence is safer".

Still others persevere. One individual wondered, "When will I become real?" Another individual commented:

> I must eliminate the need for defense. I must reduce the degree to which I am controlled by others, the dependency upon the approval of others. I'm on my way to increasing that freedom. I know that I have needed and will continue to need others to validate my own experiences and intuition, but I'm going to need them less to control my opinion and behavior.

One man reported about his developing acceptance of himself:

> Actually I should not say that the encounter with T. was distasteful; more accurately, I should say that T. was distasteful, while the encounter itself gave me a measure of satisfaction. It was satisfying because I have been growing weary of the "nice guy" image that I seem to be acquiring wherever I go and here was a guy who really disliked me and was telling me about it. I found that I was able to listen to his bullshit, dismiss it for what it was, retain my self-image, and go on living perfectly happy with the knowledge that somebody out there finds the very sight of me repulsive to him.

Another man, who was viewed by the group as using his "silver tongue" as a way of keeping others at a distance, disclosed:

> ...I admitted that for one of the few times in my life I was finding it difficult to speak--because in my struggles since yesterday I have learned that I use words to close off others from communicating their feelings to me...(use of words and other devices as a way of running away from the pain of others and my own true feelings). The group cheered and applauded. That was a great moment because the applause was not for the veneer/mask of me. It was for the REAL ME!! (Actually, I should have applauded the group for helping me to become more real).

"Seeing one's self in others" enabled some members to begin to "let down the guard" and identify with the group. As one woman revealed:

> ...yet I couldn't comprehend or feel the impact of this (confrontation) until I saw myself in J. In J. I could see my difficulty in trusting people, my, therefore, seeing the group as a game, my need to comprehend, and reject what I couldn't comprehend, my need to be in control and imply conditions...

> ...Crying over myself as J. held the mirror (she means his actual behavior) helped me resolve the incomplete, dissatisfied feeling I had; of being disgusted with myself for being a coward and a cop-out, for not having the courage to face myself. It helped me resolve the creeping feeling of anxiety within me, the sinking feeling in my stomach, the feeling of physically being ill. I faced me in J.

Another woman reported her reactions to the same interaction:

> One incident during the T-group meeting seemed especially important to me. This occurred between J. and S. after they had been characterized as among the more inept members at communication of feeling. S. was crying in a crouched, almost fetal position. J. sitting next to her reached out to comfort her. The awkward hesitancy of this gesture was most expressive and deeply moving.

An older professional nurse disclosed how the program had made her aware of disparities between her professional and personal identities. She said:

> It was walking to lunch with R. that I saw myself as having two very different personalities--one for the work world, and one for my social life; the one dull, cold, hesitant, tense, holding-back, non-communicative; the other warm, interesting, creative, tender, yakking and relaxed. <u>What bothers me most</u> is that I'm loosing the second one as time goes by, and am becoming stodgy and boring. Discussion following the replay of the AV (audiovisual) tape brought things to a head for me and I (first time) allowed the group to help me...I've much to assimilate, but things have got to change for me and I intend to put together some new approaches so things will change--for me and the people I interact with.

When individuals are able to bring patterns of behavior to a conscious level, questions can then be asked and alternatives considered. This is reflected in the following accounts.

> Integrity is the priceless ingredient for which I had been searching--and, although I am in the integrity business, or maybe because that's my business, integrity seems to have eluded me when I've most needed it. So as I shared with the group on Thursday, I've begun to learn how to feel. I'm

> moving, I like myself, changes are coming, I'm frightened. I have been using up so much emotional energy in the deceptive process, it seems such a waste... ...I am flooded with deep feeling for the group, the staff, myself. It (the ongoing scene) also put me in touch with my inability to choose to leave a situation, or to be angry or to do any number of things. When, in fact, these choices are available to me. It's really kind of neat to become aware of these choices. My system is beginning to open up more.

It seems appropriate to conclude this section of the report by quoting the final entry in one young nurse's diary:

> As the end of the course is almost here, I've been trying to pull some of the things together. It's hard to believe that three months have passed. I realize that it has passed but it's hard to say good-by. I realize that I must take what I've learned here and continue to build on it. Some of the major things that I think I've learned during the past months are:
> 1. I've regained the faith I once had but lost, in myself. I was beginning to feel helpless in more and more situations. I suppose that I haven't completely lost some of that but I am aware of it and can continue to work at preventing it from ruling me.
> 2. I've regained a faith in people that I've been trying desperately to hang on to. It has had great meaning for me to meet warm, friendly and helpful people. I was beginning to feel that all people pushed, shoved, knocked each other down and just didn't give a damn about anyone other than themselves. I really didn't want to believe that but everything seemed to be pointing in that direction.
> 3. I've learned what it's like to relate to women in other than a superficial way. Women always turned me off, in general, because they seemed so irrational and catty. So in the past I had formed few close relationships with them. I've learned that there is a special kind of meaning and satisfaction obtainable from this kind of relation. In a way I feel like I've gained many sisters.
> 4. I had felt that one either had to be strong or weak. Most of the people I knew seemed to be either too weak to stand up or so strong that they didn't need anyone. I guess I leaned more toward the strong side. As a result I never asked anyone for help. I feel that I've learned that to ask for help doesn't mean that you're weak and that it can be good to be able to ask for help. I feel that I've learned to be able to ask for help and I believe that I will be able to do so in the future.
> 5. I've begun to give myself credit for having effect on people. Many times I've never even considered the

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> possibility unless I had done some obvious helpful thing. These are just a few that I am able to verbalize. I'm sure I'll see more things as I move away from this experience to the many more awaiting me. Thank you for helping me to recognize the tools that I do have available.

INTERVIEWS

Because of the orientation that values the system approach, and because of the relevance of one system rule i.e., a change in one part of the system affects all other parts of the system, follow-up interviews were conducted not only with course graduates, but also with spouses and professional colleagues.

Program Participants

In addition to the information contributed by trainees during the course of the program, some participants were also asked for their retrospective comments during a follow-up interview. The following excerpts again highlight the diversity and complexity of individual experiences.

For some trainees the most significant growth occurred in the area of emotional learning rather than cognitive learning.

> ....The value of the class for me was that it was emotional learning--not just a head trip. And now two years later the learning is still with me and is useful.

> I am now three years married and feel very much that we have a strong good marriage. I consider that an achievement since I was very lonely and walled off from living before the CHS experience. I saw myself as a "mouse" with many strong feelings, particularly anger, not really feeling close to any one and not knowing what to do about it. I feel more able to extend myself to others in a real way. I feel warm with others, and can show warmth.

> I learned that I had to look carefully into my own needs and meet them in order to help others meet theirs. I see more clearly that there is a middle road about following feelings in that feelings have to be tempered with reason.

> I'm not the same person I was before CHS, and even though I have not let my hair grow long or even longer, I feel different and behave differently also. And I feel it's better. Others tell me so too. In addition, other people have more competencies than they had previously. Remarkable!

For other trainees developing an awareness of the freedom of choice led to an increased feeling of competence as well as a greater willingness to take risks.

> Through CHS I became aware of how optional misery can be. I did not expect all that pain, all that candor, all that caring by the group and the staff despite my arrogance, egocentricity and garrulousness. Because of the candor, caring and pain, I am finding it possible to change parts of myself that I don't like.

> Every day I realize how changed my life is! The whole frame of reference is different. Rather than doing what I think is the expected thing I can choose to act in a way that fits for me and makes sense to me. This was a whole new way of living that I learned at MRI. My family and students respond in a more honest way because they are freer to use the same rule. I take risks and when things don't work I know it isn't the end of the world. I can try again in a different way.

> I am more sure of myself,
> More fond of myself,
> More myself!
> Learning about and permission to choose alternatives I didn't even realize existed opened up an entire world for me.
> I have found that I am more self-confident and thus more willing to take risks than before.

By far, the most frequently mentioned change that was valued was increased self-confidence.

> I have more of an outreach towards others that was

> not there before. I am more able to take a definite stand on opinions and beliefs with determination. I don't feel such a great need to be praised for things that I accomplish but am more satisfied that the work was accomplished.

> I have a better sense of self, a stronger ability to assert myself, the ability to meet strong authority figures with a sense of equal worth. More insight into my defense mechanisms.

> For the first time in my life I feel I'm a participant in life because I'm me. I don't hide behind the fact that "I'm just a nurse". For the first time I feel like an adult among adults, not a child in a group of grown folks. I can even use my Ph.D. when appropriate and feel good about it.

> I have come more and more to rely on myself, to trust my feelings and perceptions, to act on them, and to learn from the consequences rather than judge myself. This puts me in the driver's seat in my life. I find I am developing more realistic relationships based on what I see and hear rather than on how I wish it were.

> I am learning to be what I am and less what other people expect me to be. If these two coincide, it's a bonus. If not, I am learning to live with it.

The experience of one individual was unique in that she was facing retirement with mixed feelings after a successful and brilliant career in the academic world. One of her personal goals in taking the course was to awaken herself to the reality of her years and the opportunities that life held for her. Exposure to different disciplines during the class itself, different age groups, points of view, orientations, ethnic backgrounds, proved useful to her in broadening her outlook and possibilities for herself. Although she is moving into retirement, that is not the most apt description of her. She is moving into another phase of living and securely reaching for its consequences. She is finding her area of interest, is moving out into the community with

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more personal involvment (not talking about but doing). CHS experiences broadened her outlook, made her aware of more choices.

For some trainees, despite individual counseling, the CHS experience contained elements of regret or disappointment.

> For me the course was about nine months too short. I was not able to assimilate the experience at the time. I needed more time.

> I learned how difficult it is to change one's self let alone a group!

> I expected to have some kind of almost magical transformation into an "all loving, free spirit" --and that did not happen.

> The course came at a time when my life was in considerable turmoil. So much of my attention and energy was required in dealing with my own problems that I didn't have much left to invest elswhere. I feel cheated and wish I might have another opportunity to take it as I feel at a different time in my life I could have made much more use of it. I would like to take the course again, starting where I left off. I think I could get a great deal more out of it. I was so walled off and fearful, I wasted so much time learning to trust.

One important goal of the CHS experience was to foster the integration of the learning in order to enhance professional effectiveness. The following comments from trainees reflect the impact of the program on their professional roles:

> Professionally I feel very satisfied and successful. Probably the greatest change in my actions and attitudes directly related to my CHS experience are in my ability to show warmth to the clients and staff in the program. It feels great! I organized a national consultant firm with four other professionals. At the very least the effect of starting something unique is exciting and fun! The studies in systems and communication are useful daily. The group experience helped me free some personal hangups.

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After attending CHS I analyzed my work system and my own needs and likes. I found that I had the best job in the department for me. At this point I am not interested in any "higher" administrative job in the department. I'd rather use my energy in developing my present one.

I have been through a period of uncertainty and political conflict in my job. I have felt unfair tactics were being used. Through it I am finding out what I believe, my strengths, and that I am a worthwhile person and cannot be destroyed. I feel congruent!

I have a new job in teaching and find I am more involved with communication than physiology. It is a completely new program so I can put my ideas into the system which I am doing with much success. I am happy teaching. I didn't always feel this way.

I feel I am a much freer person and am not afraid to experience the rough times as well as the good. I feel I'm not locked into a particular kind of behavior system and can try out new ways and not feel guilty. I am more confident in my ability but more important, I feel I have learned to be patient and thus gleaned understanding about situations and systems. I have been involved in a systems change and thus witnessed the principle that a system must change to accomodate new parts. With support from MRI staff and my husband I have been able to stand on what I believe in. Results have been that the mental health department of this county is being reorganized and nursing is becoming a recognized discipline within the department.

Learning a new approach (systems) and family theory and the opportunity to practice in my field placement were all most valuable in my professional growth. This experience was largely responsible for my shift into the community mental health aspect of psychiatric nursing and most useful in developing a new program as part of my teaching role. I believe systems theory should be used throughout nursing curriculum.

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I'm more aware, mature, and self-confident in all aspects of my life. I interact in a more effective way. Students comment to me that they appreciate my approach to them, and co-workers who are not frightened of open trust and honesty regard me highly. Some of the "old guard" are really threatened by me.

I think living through the field placement which provided me external expectations, the knowledge that I don't have to have as much structure as I though I needed, has freed me to be more creative professionally.

I feel good about my professional life. For the first time in my life, I feel I have some power professionally. I feel a reasonable degree of competency in my professional performance. I like my job very much as opposed to the stifled feeling I experienced in my previous one.

I have become more assertive. I have something important to contribute. I look at the dynamics of the system, evaluate where I can best plug in. I am becoming more aware of the emotional needs of colleagues, I am not as critical and fault-finding.

When I left MRI I made a committment to be more selective in the kind of activities that I would participate in and to use my expertise in the areas where I could perhaps bring about changes that would improve the quality of life for larger numbers of people. At the same time I have been willing to help individuals and families who are having difficulties.

When I entered the CHS program I was very negative about nursing. Now I intend to remain in nursing as I see many opportunities to use my skills that I was not aware of before.

How much more satisfaction I find in my work and interpersonal relations as a result of my time at MRI!

I feel so much better about myself and freer to function as me. You wouldn't believe how much more direct I am with conferees, staff on all levels, and patients.

I am pleased with my own performance and competence --this is a new experience for me!

Except for my MRI experience and learning, I'd be too paralyzed to even think of taking on a teaching position, let alone developing the whole damn curriculum as the course is being taught yet! But I'm relatively calm and self-confident. I still can't analyze or even imagine what it was that helped me to change and to feel better about myself and my abilities, but those gains, whatever they were and however they happened, are still with me and growth still goes on. I was made to feel that I am good, that I am important to myself and to others, and that I have important things to do. I am limited only by limitations I put on myself.

That which I was doing "undercover"--working on the research unit--I am now doing with official sanction. I have managed to make a change in an incredible bureaucratic system.

I have come more and more to rely on myself since CHS --to trust my feelings and perceptions--to act on them and to learn from the consequences rather than to judge myself. This puts me in the driver's seat in my life. I find I am developing more realistic relationships based on what I see and hear rather than on how I wish it were.

I think the MRI experience has done more for me as a person than any other single experience I can recall--it has helped me to see myself in a better light, as being attractive, truly having a lot going for me. At the same time I am well aware of my hangups, and short-comings. I find I can be more open with expressions of reactions, ideas, feelings without wondering how others are going to react to my opinion or stance.

I have just gone through a hectic year at work--

> reorganization, staff changes, anxiety. I felt I started the year with a new bag of tools, after the CHS program. I was able to sort out some of what was happening and deal with it in a less threatened way. I felt useful in helping others make sense of it. I find I feel different about people and relate in a more direct way, with both students and faculty, more accepting and I feel more accepted.

> My field experience broadened my frame of reference to include nurses as change agents outside of the hospital.

Some participants returned to stress situations they had not anticipated: systems too rigid to tolerate new information and ideas or systems where power struggles developed in the name of progress.

The outcome for some was termination of the job, for others, termination of significant personal relationships. In each of these instances, however, there remains a glimmer of success for the individuals have emerged from these experiences with some new, useful knowledge of themselves and themselves in relation to the system.

It is, perhaps, impossible to measure precisely the ramifications of the CHS experience; life is after all an endless process of education. It is possible, however, to mark the CHS experience as a catalyst which fosters this educational process and moves the individual into a more meaningful awareness of life which allows him to see the possibilities for change not only in himself but in family and community systems as well. That this momentum has allowed the participants better to understand the niches of the systems in which they function, that it has allowed them to witness the heights and depths of communication and reflect upon a procedure for improvement, this is truly a measurement of human growth.

Spouses of Participants

Most spouses contacted were eager to be interviewed and to express their personal impressions; most viewed the CHS experience as far-reaching and affecting not only their mates but themselves as well. Questions, fear, and anxieties were often present; for some there was a mystery about "what went on at MRI". This subtle fear is, perhaps most explicit in one wife's impressions of her husband's response to the course:

> After two days at MRI each week, A. came home different --serene, more at peace, "someplace else", quiet and thoughtful. I couldn't understand what it was about and his explanations didn't dissipate my fantasies or relieve my anxiety. I liked the changes I saw and felt in him and our relationship, but I felt he might be moving away from me and I might lose him, and it was frightening.

However, after a visit to MRI in which she could voice her concerns, meet and talk with staff, and receive some direct feedback which acknowledged the importance of her own role in her husband's growth process, she too felt the energy which had inspired her husband. And it became most gratifying for her as well because "now what A. was involved in has realness for me too".

That this involvement did not have the same measure of reality for all the spouses was apparent in one area of major concern -- the twenty-four hour marathon. The same intensity that was felt by A.'s wife was dramatically projected in varied reponses (some resentful, others enthusiastic), all of which stemmed from the mysterious quality of the marathon -- the unknown force that it possessed, its potential to foster change.

> I resented her going to the marathon because I was afraid of what might happen. She had a hard time getting herself together afterwards and I wondered if it was worth it. It bothers me.

> The marathon was a high point for B. He seemed like a different person when he came home and has

> continued to be more open, thoughtful and loving. Our marriage is stronger, happier; we feel closer. I didn't know that was possible. Because of his experience I have participated in a weekend growth experience and feel positive about it. I wanted a similar experience for myself if possible.

> My wife still expressed (two years later) that the marathon was painful and traumatic and questions its value. However, I see changes in her that I value (less shy and mousey, more womanly, surer of herself) stemming from that experience and that pain.

One wife comments in general:

> I can see changes in C. He has become more sensitive, more sharing, we have a different feeling in our family. He is happier in his work. I am jealous. I wish I could have a similar experience for me.

Another:

> I hated to see the course end. D. was so excited and together when he'd come home. He was so much more open about sharing his thoughts with me and what was happening. I find this is still continuing a year later, and our marriage is stronger. I feel our family is more important in his life.

The follow-up interview had ramifications beyond information gathering and, perhaps, these consequences most dramatically illustrate the course's effectiveness. By asking the spouses for opinions, they too became directly involved in the program; they sensed the importance of their own role and in some cases their own individuality for the first time. One instance of such a revelation is graphically drawn by the following comments:

> I feel so left out of E.'s professional life which is almost all of his life. I'm proud of him but I resent being so separate and I don't know how to change the situation.

This disclosure opened the door for exploring communication patterns and possible options. Later she reported:

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> I'm not sure just how it is happening, but something is different and I'm not feeling left out anymore. I feel more a part of our total life.

In other cases it is the participant's own development which fosters this growth in the spouse:

> A difference I notice in T. is one of hearing. He listens to others and he can hear feedback about himself. He doesn't always have to dominate, can share the limelight or even sit back. He just seems more comfortable with himself, doesn't seem to ask for constant reassurance. It hadn't really occurred to me until just now when we are talking about change in T., but I've changed too! I feel freer, calmer, and happier. I'm not aware of when or how this is happening.

Work Supervisors and Co-Workers

When interviewing the work supervisors of the participants, the intensity of emotion which the spouses felt (the joy, the resentment, the general concern) seemed to be replaced by more objective responses; what was fear, enthusiasm or insecurity for the spouses became approval or questioning with the supervisor's analysis; what was felt to be a personal transformation by the spouses, the supervisors saw as an essential unwillingness to be satisfied with the status quo and risk change for increased performance and satisfactions.

The director of a university counseling department comments:

> I see M. approaching a new assignment with enthusiasm, optimism, strength, and enjoyment. I couldn't see this happening six months ago. From my previous association with him he would have been somewhat fearful, nonassertive, apologetic, and hesitant to try a new role. He is less tyrannized by the demands and needs of others, more confident with himself and accepting of others.

The director of nurses in a general hospital reports:

> L. has had a promotion since she took the CHS course, now is head nurse in a psychiatric unit. I see her as a "stronger" person. She is more involved in the total system. She takes responsibility for herself, decision making, policies. She can risk being unpopular.

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A mental health system in San Francisco gave two clinical specialists release time to take the course. Comments of the Director:

> X. needed help in her relationships. Something stood in the way of her effectiveness. Y. needed help in learning to recognize her strengths. Since the CHS course X. has become warmer, less defensive, more human. Her effectiveness with patients and staff has increased noticeably. She is becoming a teacher who can teach. Y. is talking more clearly, can be heard, functions with more strength. The released time was more than justified for both in their increased involvement and performance. I would like to have participated in your program myself.

The supervisor of a young nurse with a special interest in pediatrics in a mental health center in the midwest reports:

> Z. came back from her three months in California changed in various ways. She looks better! Her physical appearance has improved, she seems more aware of the impact of her total being. I had always been aware of her creative potential but she has become aware of it to the extent we find it sometimes difficult to keep up with her ideas and program development. At times she is overwhelming in her energy, enthusiasm and accomplishments. Examples:
> 1. Developed program and is teaching staff of obstetrical department in a general hospital placing emphasis on total family rather than birth procedure.
> 2. Working with school of nursing to incorporate above principles into obstetrical curriculum.
> 3. Developed and demonstrated a program for working with young unwed mothers -- two ongoing pilot groups.
> 4. Participates in TV and radio shows dealing with problems of children, teenagers, and parents.
> 5. Is participating with staff development at state hospital.
> 6. Is available for consultation for school, church, and civic groups dealing with problems of communication.
> 7. Functions in ongoing therapy with individuals and families. In all she does she functions with personal warmth and good humor. She constantly has to struggle with setting realistic limits for herself as her services are in constant demand.

Eighteen psychology trainees from the Veterans Administration Hospital participated in the program. The director of training for the V.A. program expressed loss at the termination of CHS. He reported that it

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had a unique value because training in the university setting emphasizes the ideological and added that this program exposed trainees to a different kind of learning not available elsewhere: personal exploration, experiential learning with the emphasis on the here and now with each individual becoming aware of his part in the outcome of interaction. He believed that for most participants this was a new approach and for most proved to be an enriching experience adding a dimension to their professional growth allowing them to "risk more flexibility".

In a criminal justice system from which fifteen employees participated, a supervisor reports that he has observed some individual change and a more cooperative attitude among particpants. However, he feels that had trainees been selected from more strategic postions in the system hierarchy the effect on the total system itself might have been more significant. He seemed to think that much individual effort for change was lost in the bureaucracy of the total system. Even so, using systems concepts and his own creativity the training officer is implementing a new approach to juvenile justice which could radically change the system.

In a neighboring county, the director of a similar justice system reports that participants in the course have made a noticeable impact. He adds that individually the participants demonstrate an awareness of options and an ability to see goals more clearly and, then, to move to make them a reality with more candor. This has led to shifts both within the department and out of the department allowing more challenge and satisfaction in role performance. He reports more risk-taking in expressing dissatisfactions and moving toward change -- both personal and within the system. Finally he concludes that the participants in varying degrees have had an effect on the total staff by demonstrating more openness, more direct communication patterns, more personal regard for others. "From my observation both from a personal response and a

system response, the time released for this program has been much more than justified".

SUMMARY - PROGRAM OUTCOMES

Chapters Four and Five have reported program outcomes relevant to the study "What are the effects on the self-concept of graduate health professionals of participation in an interdisciplinary group experience which focuses on communication and human systems theory?"

GENERAL HYPOTHESES

1) Graduate health professionals will value an opportunity to participate in a supportive interdisciplinary group experience focusing on communication and human systems theory.

This hypothesis was supported by the following information:

a) During the course the attendance was excellent and the level of active participation was good.

b) At the end of the course REQ scores were above the mean for all six program components.

c) Following the course, 88% of the evaluation questionnaires were completed and returned.

2) Graduate health professionals who participate in a supportive interdisciplinary group experience which focuses on communication and human systems theory will demonstrate a changed self-concept on completion of training.

This hypothesis was supported generally by the subjective, qualitative data gained from the diaries and follow-up interviews.

SPECIFIC HYPOTHESES

1) There is a positive relationship between participation in the CHS

program and self-acceptance change scores.

This hypothesis was supported since no Time 2 group mean score of "percent positive feeling about self" of the IOU fell below the Time 1 group mean score.

2) There is a positive relationship between participation in the CHS program and increased self-esteem.

This hypothesis was supported since all groups except Group 5 showed an increased self-ideal self correlation at Time 2 testing that was significant at the $<.05$ level (Wilcoxon T).

3) There is a positive relationship between self-acceptance change scores and other-acceptance change scores.

There were mixed findings for this hypothesis. The group mean on the Berger self-acceptance scale increased for each group at Time 2; however, the expected corresponding increase in Berger Other-Acceptance scores did not materialize.

4) There is a positive relationship between increased self-esteem and increased self-actualization.

This hypothesis was strongly supported since RAT Time 2 scores increased at the $<.05$ level for 8 of 10 groups despite the stability of the instrument reported in the literature.

5) There is a positive relationship between increased self-esteem and increased professional self-acceptance.

The use of the Semantic Differential did not support the hypothesis of consistent related change since only 21 of the 57 concept measures reached levels of significance.

6) There is a positive relationship between increased self-esteem and increased occupational effectiveness.

This hypothesis was generally supported by the feedback given by colleagues and supervisors during follow-up interviews.

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In addition, the expectation of an ordered increase in test scores over four administrations did materialize. Using the "L" test the change for post-grad Group I and Group II was significant at the $< .01$ level.

CHAPTER SIX - THE POST-GRADUATE PROGRAM

One of the more significant outcomes of the basic CHS program was the development of the post-graduate sequence.

PROGRAM DEVELOPMENT

Based on staff observations, trainee self-reports, reports of significant others in the trainees' work setting, and preliminary evaluation data, the majority of participants in the basic program had demonstrated increased personal and professional competence at the completion of the CHS course. However, the question of the permanence of this growth had yet to be answered. Also, after being back on the job for a period of time and testing out some new skills and behaviors, several graduates began requesting additional training. Consequently, a questionnaire was sent to all trainees who had completed the basic program by December, 1970, asking for a show of interest in a post-graduate workshop. It was hoped that enough graduates would be interested in an advanced workshop so that one or two pilot groups could be offered. Data from these groups would then be available from which recommendations could be made for any further research or program development. Surprisingly, of the 130 questionnaires sent out, 98 replies were received which included requests for follow-up workshops from 86 graduates, including 45

nurses. Having had a chance to put to use the knowledge and skills developed in the basic program, the trainees expressed a need for a more personalized and intensive advance learning experience. In response to the question regarding preference for primary content of the workshop the following votes were tallied: brief therapy - 52; family therapy - 46; group dynamics - 45; system laboratory - 41; lectures - 14; field trips - 14.

Utilizing the information from the questionnaires, a format was devised which was followed for two pilot sessions of post-graduate training (Appendix H). These intensive, eight week clinical programs were offered to CHS graduates from Groups 7 through 11 in order that matched data over time would be available. The evaluation packet included: 1) Inventory of Uniqueness, 2) Remote Associates Test, 3) Berger Attitude Scales, and 4) Semantic Differential, all of which the trainees had completed on a pre-post basis during their earlier training. Therefore, at the end of the post-graduate program a series of four scores for each trainee on the 11 variables obtained from these instruments would be available. It was hypothesized that additional clinical training would reinforce the changes in Self and Professional Self-Concept brought about through the experience of the basic course. Therefore, an ordered increase in scores over the four administrations (i.e., pre and post basic course and pre and post post-graduate course) was expected. To test this hypothesis the "L" statistic (Page, 1963) was used.

PROGRAM PARTICIPANTS

The first post-graduate training program was scheduled from September 1, 1971, to November 19, 1971, and included 8 trainees; 6 women who were nurses and two men, one a nurse and one a psychologist. Post-graduate Program II began on February 3, 1972, and ended March 31,

1972. There were ten trainees in this group, five of whom were women (all nurses) and five of whom were men -- one nurse, one psychologist and three probation officers. Table 12 contains additional demographic data on the two groups.

In February, 1972, an attempt was also made to set up a control group for post-grad Group II, i.e., ten trainees who were matched for sex and original group and who were not going to be taking post-graduate training. Although packets of the evaluation instruments were sent to these trainees at times corresponding with the post-grad group testing, only 60% of the material was completed and returned and therefore did not constitute an adequate control.

RESULTS: POST-GRADUATE GROUP I

All of the students who started the program completed the program and completed all of the evaluation instruments. Therefore, the N of eight remains constant. Table 13 illustrates the use of the "L" test (a significance test for linear ranks) to demonstrate the effectiveness of the evaluation package in measuring change over time, i.e., T1, T2, T3, and T4. The "L" total of 302.5 is significant at the $<.01$ level, which verifies an ordered increase of group scores over the four administrations for all eleven variables. Also, looking at the scores for the individual instruments, trainees obtained a perfect ordered increase over time on three variables: Berger - Self-Acceptance Scale, Semantic Differential - Women; and Semantic Differential - Men.

When the "L" test was used to evaluate the significance of each trainee's scores over time, from Time 1 to Time 4, on each instrument, the results shown in Figure 5 were obtained.

The Wilcoxon T was also computed in order to compare trainee change scores between the Time 1 and Time 4 administration of each instrument.

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TABLE 12

CHS Post-Graduate Trainees

	Student	Age	Sex	Degree	Specialty	Where From
Post-Graduate Group I	1	26	F	MS	Child Psychiatric Nursing	Palo Alto
	2	31	F	M Ed	Psychiatric Nursing	Saratoga
	3	27	F	MS	Psychiatric Nursing	Palo Alto
	4	29	F	MS	Psychiatric Nursing	San Jose
	5	40	F	MS	Nursing Education	San Francisco
	6	57	F	BS	Public Health Nursing	Sacramento
	7	30	M	Ph D	Psychology	Palo Alto
	8	39	M	RN	Nursing	Modesto
Post-Graduate Group II	9	53	F	MS	Psychiatric Nursing	Moraga
	10	32	F	MS	Psychiatric Nursing	San Francisco
	11	47	F	MS	Nursing	San Francisco
	12	34	F	MSN	Psychiatric Nursing	Oakland
	13	25	F	MS	Psychiatric Nursing	Palo Alto
	14	32	M	RN	Psychiatric Nursing	San Jose
	15	34	M	Ph D	Psychology	Palo Alto
	16	41	M	BA	Probation	San Jose
	17	34	M	Ph D (C)	Probation	Oakland
	18	45	M	MA	Probation	San Mateo

TABLE 13

Post Graduate Group I

Comparison of Group Means Over Time Using the "L" Test

Instrument	T_1	"L" Rank-1	T_2	"L" Rank-2	T_3	"L" Rank-3	T_4	"L" Rank-4
I O U	.428	1	.715	4	.540	2	.648	3
R A T	.624	2	.625	1	.808	4	.779	3
Berger-Self	3.95	1	4.16	2	4.21	3	4.29	4
Berger-Other	3.93	4	3.80	1	3.85	3	3.82	2
SD-Self	5.75	1	6.15	3.5	6.15	3.5	6.04	2
SD-S/Prof	5.91	2	5.01	1	6,29	3	6.33	4
SD-S/Sup	5.69	3	5.43	1	5.75	4	5.54	2
SD-S/Pt	5.99	1	6.21	2	6.35	4	6.31	3
SD-Prof	5.55	2	5.77	4	5.24	1	5.58	3
SD-Women	5.85	1	5.91	2	6.15	3	6.26	4
SD-Men	6.03	1	6.17	2	6.20	3	6.26	4
"L" Sum		19 x1		23.5 x2		33.5 x3		34 x4
"L" Subtotal		19		47.0		100.5		136
"L" Total	=	302.5		=	P	$<.01$		

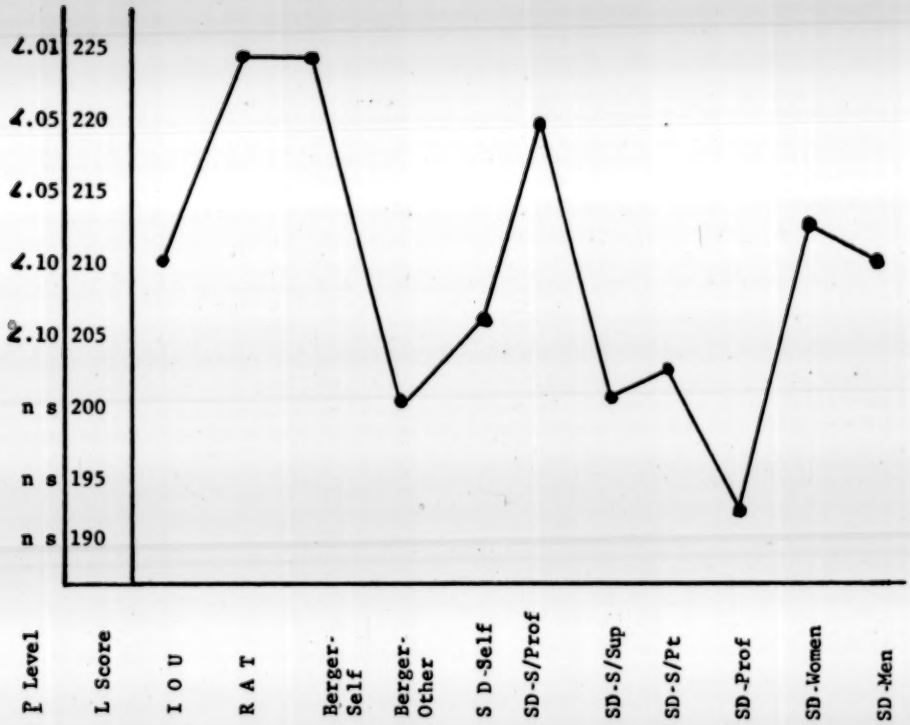

Fig. 5 Significance of Each Trainee's Scores Over Time Using the "L" Test

A significance level of .05 or less was reached by the Iventory of Uniqueness, the Remote Associates Test, the Berger Self-Acceptance Scale, Semantic Differential-Self as Professional, and the Semantic Differential - Women.

RESULTS - GRADUATE GROUP II

All ten trainees in Group II completed all of the evaluation instruments with the following results.

The calculations using the "L" test again showed an ordered increase in group mean scores over 4 testing times. Also, the trainees in post-grad Group II achieved a perfect ordered increase over time for two variables: the Remote Associates Test and the Semantic Differential - Profession. The results are shown in Table 14.

The Wilcoxon "T" was also computed in order to compare trainee change scores between the Time 1 and Time 4 administration of each instrument. A significance level of .05 or less was reached by the Inventory of Uniqueness, the Remote Associates Test, and the Semantic Differential factors for self, self as a professional, profession and women.

SUMMARY

Eighteen CHS graduates (8 in Group I and 10 in Group II) received additional in-depth training. The data from both groups support the hypothesis that the post-graduate clinical program would reinforce the original CHS training.

TABLE 14

Post Graduate Group II

Comparison of Group Means Over Time Using the "L" Test

Instrument	T_1	"L" Rank-1	T_2	"L" Rank-2	T_3	"L" Rank-3	T_4	"L" Rank-4
I O U	.441	1	.705	3	.647	2	.708	4
R A T	.603	1	.697	2	.777	3	.847	4
Berger-Self	4.20	2	4.18	1	4.40	3.5	4.40	3.5
Berger-Other	3.89	4	3.87	3	3.84	1	3.86	2
SD-Self	5.77	1	6.12	3	6.03	2	6.37	4
SD-S/Prof	5.87	1	6.12	3	6.05	2	6.92	4
SD-S/Sup	5.72	3	5.92	4	5.33	2	5.12	1
SD-S/Pt	5.93	1	6.29	4	6.07	2	6.12	3
SD-Prof	5.07	1	5.17	2	5.20	3	5.61	4
SD-Women	5.29	1	5.92	3	5.84	2	6.00	4
SD-Men	5.52	1	6.03	4	5.92	2	5.93	3
"L" Sum		17 x1		32 x2		24.5 x3		36.5 x4
"L" Subtotal		17		64		73.5		146.0
"L" Total	=	300.5		=	P	$\angle$.01		

CHAPTER SEVEN - DISCUSSION

This discussion of the study of a special interdisciplinary group experience for graduate health professionals will be divided into three parts. Section one will examine special issues as they relate to the program format, the program participants and the program outcomes; section two will suggest some possible interpretations of the data; and finally, section three will detail the conclusions and some recommendations for future consideration.

ISSUES

Program Format

The unifying focus of the CHS experience was to develop an understanding of system theory and of an individual's relationships to the various systems of which he is a member (Parsons, 1951; Baumgartel, 1964). Sorrels and Ford (1960) have documented that in family systems as in other feedback systems, what effects one member effects all members. However, a seeming paradox of CHS was that the course was purposely set up to enable individuals to have a potential growth experience in a neutral setting (Duncan and Kempe, 1968) by removing them from their familiar groups and settings. Hence possible constraints on communication and behavior style resulting from role prescriptions of existing institutional affiliations (i.e., office, family) were reduced. It was also

assumed that an individual would be more likely to "unfreeze" and practice new behavior in a "safe, new group" (Henle, 1962).

In order to get a sense of how cognizant an applicant was of the complex interactions of these factors, several special questions were included in the screening interview.

"With whom in your family have you discussed the possibility of being in this program?" "What are the rules in your family about the permissions people have to change?" "What communication styles do you have that can build bridges between your own experience and the members of your family?" "What does your family understand about such matters as privileged communications?" "What if you are preoccupied and fatigued at the end of a very involving day of the program, and are able only to say to your family, 'I can't discuss this because it is privileged communication'?"

Attempts that were made with the earliest groups to involve the spouses or significant others in a direct way (such as attendance for half-day sessions or being invited to luncheon or dinner activities) seemed to raise more questions than they answered. These were soon discarded in favor of relying on the applicant to assume the responsibility of building and/or maintaining adequate channels.

The concern for "neutrality" and separation from the work system was balanced by the question "how effective is a solo agent in bringing about system change (Bennis, 1966)?" Would two individuals having an experience at the same time reinforce each other's behavior change? Would having a trainee-team-mate facilitate implementation of desirable program changes in the agency? It has been reported that individuals who participated in successive CHS programs did join forces subsequently in their work settings. In later groups, the importance of identifying the kind of system as well as the relationship of the two people in the system

emerged as important determining factors. Subsequently, several individuals from the same system did attend the program at the same time and did have successful personal and professional growth experiences.

The evaluation aspect was another fundamental component of the program. However, a surprising number of trainees came to the course with a negative concept of testing and/or research. An attempt was made to counteract this feeling by giving the groups a detailed explanation of the evaluation design as well as feedback about specific outcomes (Mosel, 1964). Though a few members in each group continued to "gripe" about the evaluation tools, there was a high degree of dependability as far as completing and returning the material. In fact, for many, the end result seemed to be a positive experience regarding research. Also, at least a dozen trainees were later motivated to incorporate research components into their own agency setting.

The complexity of the evaluation design itself (i.e., 175 trainees, 142 follow-up questionnaires with 85 variables plus the basic evaluation packet with 12 program variables) prompted the choice of computer handling of the data. The capabilities of the Statistical Package for the Social Sciences at the time the data were analyzed were both adequate and limiting as so often is the situation (Nie et al, 1970). The program ability to produce frequency tabulations, percent calculations, ranked order, change scores and correlation measures was vital. However, though cross tabulations and Chi Square comparisons suggested trends, the ability to look at linked variables was restricted.

Program Participants

Of the 176 individuals who started training, 167 graduated from the program. Of the nine trainees who did not complete the course, five left

in the early weeks, four because of their inability to reconcile the pressures of work with the CHS program, and one because the program did not meet his expectations. One other trainee was asked to leave because of unprofessional conduct. Three individuals left in the latter weeks of the program due to experiencing unresolvable stress. It is significant to note that two of the individuals who did not complete the program because of anxiety and stress had submitted misleading reference letters, i.e., they had asked a friend or family member to write a professional reference letter without identifying the personal connection. Four other trainees experienced acute anxiety and stress during the course of the program, but with additional support from staff members and/or outside counseling were able to complete the program on a growth trajectory.

One other factor seems to be related to trainee drop out. In the early pilot groups, when the course was not very well known, the people who applied appeared to be of the type who were willing to take a chance on a new kind of learning experience although most did not meet the stated educational requirement -- that is, a Masters or Doctoral degree. As that situation was turned around, the group stress profile also changed. It seemed that individuals with the higher level of academic preparation were in the midst of more personal and professional crises with the result that later groups became less stable than earlier groups.

In addition to the 176 individuals who ultimately became trainees, another 153 women and 19 men applied to the program. Unfortunately, because of the desire to have heterogeneous groupings, many otherwise competent and qualified people were not accepted simply because someone else with similar qualifications applied first. However, several of the people who could not be placed in the program of their first choice were put on standby status or given priority for future courses, and ultimately did become trainees. Most inappropriate applicants were screened early

in the selection process. Only 13 applicants which reached the selection committee were rejected at that point.

Program Outcomes

System theory and family system theory also had relevance for the CHS program in relation to several staff crises. The initial crisis resulted from the untimely death of a key staff member a few weeks after the beginning of the first pilot group. The nine trainees commented that they felt like kids who had lost a father, and indeed, the author often felt like the surviving spouse in a one parent family. Of necessity much of the focus of the group was on the matter of loss and death -- especially unexpected death (Caplan, 1961). Due to much hard work and the unlimited cooperation of the staff and students, the problem was eventually resolved. In fact, the "working-out" of the situation proved to be so much of a learning experience for all that one staff member remarked, "Maybe we should create a crisis for each group!"

We were to be haunted by that remark when a year later a crucial difference of opinion occurred between another key staff member and MRI administration. This seemed to be based partly on a misunderstanding and partly on divergent philosophies. In any event, never was the axiom "systems play follow the leader" (Sorrells and Ford, 1969) more clearly demonstrated. The project lost another leader, members of the staff lost respect for each other and the trainees lost faith in both the staff and the program. What developed was an experience of "cognitive dissonance" (Festinger, 1957). The discrepancy that caused the stress existed between the system model that had been presented in seminar and the CHS system that was observed in action.

Even though efforts were again directed toward using the reality situation as a growth experience, it is sobering to note how this incident

is reflected in the evaluation data for Group 4. Whereas Group 3 has the highest overall mean score on the Retrospective Evaluation Questionnaire (9.82) of any in Groups 3 - 12, the Group 4 Score plummeted to an all-time low (7.86). In addition, a very deep sense of disappointment was apparent in the remarks members of this group made three years later on their follow-up questionnaires.

The other significant crisis occurred during the last months of the basic training program and centered around the questions of the place of group dynamics in the course and the appropriate style for group leaders (Cartwright and Zander, 1968). Again, this controversy was reflected in the evaluation data. The Group 11 mean score for the REQ is the second lowest of all groups (8.46).

INTERPRETATIONS

One unique finding is that both Group 7 and Group 8 achieved mean change scores at levels of significance for six of the seven Semantic Differential concepts (Table 8). Groups 7 and 8 are also unique in that they were both double-section groups. However, if Semantic Differential positive change is related to group size (18 trainees in Group 7 and 20 trainees in Group 8) one would expect to find the same results for Group 6 (20 trainees), the only other double-section group. In fact, none of the Group 6 change scores for the seven concepts reached a level of significance. However, examination of Table 8 does reveal that all significant change scores on the Semantic Differential do cluster among Groups 7 through 12, with no scores of significance attributed to Groups 4, 5, or 6. This spread may indicate that Semantic Differential concepts are influenced as much by program variables as by participant variables.

Groups 8 and 12 were the only two groups whose change scores on the

RAT did not reach a level of significance according to the Wilcoxon T test (Table 8). However, both did show an increase of Time 2 mean over Time 1 mean (Figure 3). Examination of Figure 3 also reveals that Group 12 had the highest group mean of any trainee group at Time 1 testing, while Group 8 had the second highest Time 1 mean score. It does appear that the higher a group's pre-test score, the less likely the group is to achieve a change score of significance. Another factor that needs to be spelled out about Group 12 is that this was the only summer group. Hence, the lapsed time between Time 1 and Time 2 was 4 weeks compared to 11 weeks for all other groups.

Because of the quantity of information that was available, it was decided to analyze data collectively. Therefore, group change scores were compared. Using this measure the expected correlation between the Berger Self-Acceptance Scale and the Berger Other-Acceptance Scale did not materialize (Figure 4). However, when frequency measures of individual scores when compared using the Chi Square, a correlation of $<.05$ was reached. This would suggest the advantage (if time, money and computer capabilities allow) of working with individual scores.

The cross tabulation and Chi Square comparisons also indicated that nurses were significantly more changed than other professionals as reported by themselves and also as rated by staff. Nurses and women also report greater improvement in work relationships than other professionals or men. Does this indicate that more nurses tended to be "underacheivers" before enrolling in the program? Or was there something about the program that tended to enhance the nurses' learning experiences?

All of the foregoing discussion might be summarized by the question, "What are the structural conditions that tie to the degree of growth attained by each individual or each group?" Most of the available CHS information has to do with trainee variables. It now appears that matters

such as staff variables and program variables are equally important.

CONCLUSIONS

Team work is a central component of today's health care system, and will become an even more critical element in the near future when the promise of enactment of programs of national health insurance becomes reality. But functioning as a productive team member is dependent on an adequate sense of self and a readiness to accept others, and frequently health professionals (and especially nurses) operate from a low self-esteem stance. However, the Communications and Human Systems program has demonstrated that a modification of self-concept can occur in an intensive interdisciplinary group laboratory which provides 1) an opportunity to acquire new information and skills that are valued and 2) an opportunity to modify attitudes and perceptions through a group experience with significant others.

Utilization in training of a feedback system can move the individual beyond self and beyond profession to a position of maximum growth (Figure 6). In the input phase the individual is able to gather information from multiple sources (i.e., seeing, hearing, sensing, feeling) and then sort and select items or behaviors that have relevance. These are then acted upon in the integration phase; that is, the individual is in the state of becoming. This process yields an outcome -- the state of being. However, being is continually measured against the environment (i.e., self/others/society/world). This evaluation, or measuring, produces data or information; and the cycle is then reactivated.

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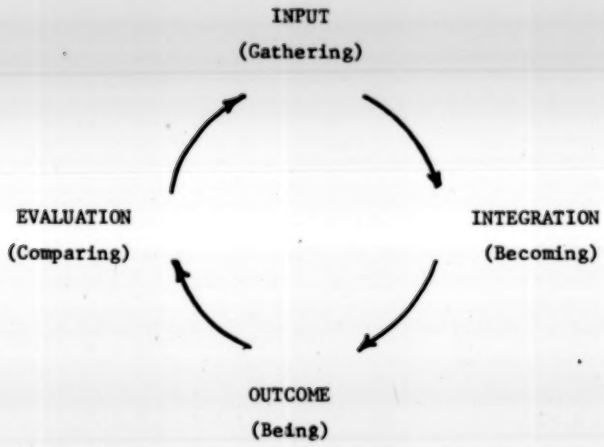

Fig. 6. Feedback growth model

RELEVANCE FOR NURSING

The experience of the CHS program as represented by the quantitative and qualitative data indicates that the majority of graduate nurses regardless of age, sex or specialty will use a structured interdisciplinary group laboratory as a growth experience. Nurses who have accepted subordinate roles because of organizational conflicts and tensions, can become more responsible reciprocal team members. Nurses whose dissatisfaction with the medical model is programming them to become professional dropouts can discover new role opportunities which in turn leads to renewed pride.

Since systems "play follow the leader", any positive change in the graduate nurses concept of herself and her attitude about her job or organization will have a "ripple effect". It will influence how other staff members or students feel about themselves and their relationships

with patients (or clients) and their families.

SUGGESTIONS FOR FURTHER STUDY

1. How do staff variables (as determined by pre and post testing and assessment of demographic characteristics) influence program outcomes?

2. What are the relationships between particular program format variables (field work, video playback, T-group, etc.) and particular program outcomes?

3. Could a CHS-like program be used as a personal and professional growth experience by para-professional trainees?

4. In plotting a re-learning trajectory, what are the correlations of direction, distance and time?

SUMMARY

This case history presented an analysis of the outcomes of a training program designed to increase the effectiveness of nurses and other graduate health professionals in solving some of the health care problems presented by today's complex needs. Positive gains in self-esteem, self-actualization (creativity) and occupational effectiveness have been described. Factors possibly related to outcomes, relevance for nursing and suggestions for further study were also included.

FOOTNOTES

1. Personal Communication, Dr. Helen Paulson, 1973.
2. Communication and Human Systems was funded by Training Grant No. MH 1D829, The National Institute of Mental Health, Division of Manpower and Training Programs, Experimental and Special Training Branch.
3. These figures refer to the number of hours in each session which was designed to coincide with the university quarter system.
4. This scale was devised by Dr. Harris Clemes for the purpose of evaluating Family Therapy Trainees. Unpublished.
5. A similar finding was obtained in response to filmed family interactions which were presented to Family Therapy Trainees in an earlier study.
6. The mean change score is consistently the mean of the differences in trainees' scores from pre to post testing and not the difference of the group's mean scores.

BIBLIOGRAPHY

Adelson, D. "Self-Valuation, Social Valuation and Self-Identity: A Framework for Research in Social and Community Psychology." Community Psychology and Mental Health, Perspectives and Challenges. Edited by D. Adelson and B. Ralis. Scranton, Pennsylvania: Chandler Publishing Co., 1970.

Adler, A. The Practice and Theory of Individual Psychology. New York: Harcourt Brace, 1924.

Ammon, G. et al. "The Terminal Phase of the Dynamic Process of a Group-Dynamic Teaching Group." International Journal of Group Psychotherapy 17(1967):35-43.

Ardrey, R. The Territorial Imperative. New York: Atheneum, 1966.

Argyle, M. Social Encounters. Chicago: Aldine Publishing, 1973.

Arnold, M.F. "Perception of Professional Role Activities in the Local Health Departments." Public Health Reports 77(1962):80-88.

Amidjaja, I. and Vinacke, W.E. "Achievement, Nurturance and Competition in Male and Female Triads." Journal of Personality and Social Psychology 2(1965):447-451.

Bailey, J. et al. "Evaluation of the Development of Creative Behavior in an Experimental Nursing Program." Nursing Research 19(1970):100-108.

Bales, R. and Borgatta, E. "Size of Group as a Factor in the Interaction Profile." Small Groups: Studies in Social Interaction. Edited by A. Hare et al. New York: Alfred A. Knopf, 1955.

Baumgartel, H. "Some Human Problems in Inter-professional Communication." Journal of Communication 14(1964):172-182.

Bavelas, A. "Role Playing and Management Training." Sociatry 1(1947):183-191.

Beard, B. and Pishkin, N. "Self-concept Changes in Training Medical and Nursing Students." Diseases of the Nervous System 31(1970): 616-623.

Beaty, W.E. et al. "Some Effects of Social Interaction on Probability Learning." Journal of Psychology 59(1965):299-306.

Benne, K.D. and Bennis, W. "What is Real Nursing?" American Journal of Nursing 59(1959):380-383.

Benner, P. and Kramer, M. "Role Conceptions and Intergrative Role Behavior of Nurses (in Special Care and Regular Nursing Units)." Nursing Research 21(1972):20-29.

Bennis, W.S., ed. Changing Organizations. New York: McGraw-Hill, 1966.

Berger, E. "Relationships Among Acceptance of Self, Acceptance of Others, and MMPI Scores." Journal of Counseling Psychology 2(1955)279-284.

Berger, M., ed. Videotape Techniques in Psychiatric Training and Treatment. New York: Brunner/Mazel, 1970.

Berkowitz, J. and Berkowitz, N. "Nursing Education and Role Conception." Nursing Research 9(1960)218-220.

Bernstein, L. et al. "Teaching Nurse-Patient Relationships: An Experimental Study." Nursing Research 3(1954):80-84.

Biddle, B. and Thomas, E., eds. Role Theory: Concepts and Research. New York: John Wiley and Sons, 1966.

Bingham, M. Beyond Psychology in Homo Sapiens Audubonienses. New York: National Audubon Society, 1953.

Boocock, S. "Simulation Games Today." Education Technology 8(1968).

Bradford, L. et al. T-Group Theory and Laboratory Method. New York: John Wiley and Sons, 1964.

Brown, E.L. Nursing for the Future. New York: Russell Sage Foundation, 1948.

XUM

Brown, R. Social Psychology. New York: The Free Press, 1965.

Brussel, B.B. "The Educational and Therapeutic Effects of the Group Process Experience." Mental Hygiene 51(1967):495-500.

Burton, A., ed. Encounter. San Francisco: Jossey-Bass, Inc., 1970.

Calkins, K. "Communication Training for Professional Development." Communication and Human Systems. Edited by E. Sorensen et al. Final Report, NIMH, Division of Manpower and Training Programs, Experimental and Special Training Branch, Training Grant #10829, 1972.

Calkins, K. "Developing an Identity and Process of Intentional Self-Change." Communication and Human Systems. Edited by E. Sorensen et al. Final Report, NIMH, Division of Manpower and Training Programs, Experimental and Special Training Branch, Training Grant #10829, 1972.

Campbell, D. and Stanley, J. "Experimental and Quasi-Experimental Designs for Research on Teaching." Handbook of Research on Teaching. Edited by N.L. Gage. Chicago: Rand McNally and Co., 1963.

Caplan, G., ed. Prevention of Mental Disorders in Children. New York: Basic Books, 1961.

Carter, L.F. et al. "Social Conformity and Attitude Change Within Non-Laboratory Groups." Sociometry 30(1967):1-3.

Cartwright, T. and Zander, A. Group Dynamics. 3rd rev. ed. Evanston, Illinois: 1968.

Chafetz, L. "The Interdisciplinary Team." USC-MSC Student Health Project. Los Angeles: University of Southern California, 1966.

Christman, L. "Specialism and Generalist in Clinical Nursing." Hospitals 41(1967):83-86.

XUM

Coffey, H. "The Significance of Group Life in Personal Change." Mimeographed. Department of Psychology, Berkeley, California: University of California, 1962.

Cohen, A.R. "Some Implications of Self-Esteem for Social Influence." Personality and Persuasibility. Edited by Hovland and Janis. New York: Yale University Press, 1959.

Cooley, C.H. Human Nature and the Social Order. New York: Scribner, 1902.

Coopersmith, S. "Self-Esteem and Need Achievement as Determinates of Selective Recall and Repetition." Journal of Abnormal and Social Psychology 60(1960):310-317.

Coopersmith, S. "Relationship Between Self-Esteem and Sensory (Perceptual) Constancy." Journal of Abnormal and Social Psychology 68(1964):217-221.

Corwin, R. "The Professional Employee: A Study of Conflict in Nursing Roles." American Journal of Sociology 66(1961):604-615.

Dabbs, J., Jr. "Self-Esteem, Communicator Characteristics and Attitude Change." Journal of Abnormal and Social Psychology 60(1964): 457-458.

Daly, N. and Heine, H. "Honesty is the Secret in Sensitivity Training." Nursing Outlook 18(1970):36-39.

Davis, A. "Self-concept, Occupational Role Expectations, and Occupational Choice in Nursing and Social Work." Nursing Research 18(1969):55-59.

Diggory, J. Self-Evaluation: Concepts and Studies. New York: John Wiley and Sons, Inc. 1966.

Dolan, J. Goodnow's History of Nursing. New York: W.B. Saunders, 1963.

Duncan, B. and Kempe, C.H. "Joint Education of Medical Students and Allied Health Personnel." American Journal of Diseases of Children

XUM

116(1968):499-504.

Earle, W. "Psychiatry Helps Policemen Do Their Jobs Better." San Francisco Sunday Examiner and Chronicle. Section B, p.7, December 8, 1968.

Edwards, A.L. Statistical Analysis for Students in Psychology and Education. New York: Rinehart, 1955.

Felton, J.S. "A Basic Interpersonal Approach to Health Education in Industry." American Journal of Public Health 57(1967):792-801.

Festinger, L. A Theory of Cognitive Dissonance. Evanston, Illinois: Row, Peterson and Co., 1957.

Flanagan, J.C. "The Critical Incident Technique." Psychological Bulletin 51(1954):327-358.

Flarshein, M. et al. "A Group Approach to Psychiatric Nursing Education." Archives of General Psychiatry 15(1966):485-491.

Fortune, H.O. "The Pros and Cons of Sensitivity Training." Nursing Outlook 18(1970):24-29.

Francis, G. "How Do I Feel About Myself?" American Journal of Nursing 67(1967):1244-1245.

French, J.R.P. "The Social Environment and Mental Health." Journal of Social Issues 19(1963):39-56.

Frerichs, M. and Frerichs, A. "Don't Overlook Class Discussions." Journal of Nursing Education 5(1966):3-6.

Fromm, E. "Selfishness and Self-Love." Psychiatry 2(1939):507-523.

Frye, R.L. "The Effect of Orientation and Feedback." Journal of Social Psychology 70(1966):205-211.

Gage, N.L., ed. Handbook of Research on Teaching. Chicago: Rand McNally and Co., 1963.

Gallagher, J. "Challenge of the Seventies." Speech delivered at National League of Nursing Ninth Biennial Convention, 21 May, 1969,

XUM

at Detroit, Michigan.

Garner, S.S. et al. "Group Dynamics in Graduate Education of Nurses." Nursing Research 14(1965):146-150.

Gross, N. et al. "Role Conflict and Its Resolution." Readings in Social Psychology. Edited by E. Maccoby et al. 3rd ed. New York: Holt, Rinehart and Winston, 1958.

Harmer, B. and Henderson, V. The Principles and Practice of Nursing. New York: Macmillan Co., 1955.

Havighurst, R. and Orr, B. Adult Education and Adult Need. Chicago: Center for the Study of Liberal Education for Adults, 1956.

Henderson, V. "The Nature of Nursing." Clare Dennison Memorial Lecture, April, 1964, at University of Rochester School of Nursing.

Henle, M. "The Birth and Death of Ideas." Contemporary Approaches to Creative Thinking. Edited by W.E. Henry. New York: Atherton Press, 1962.

Heslin, R. "Predicting Group Task Effectiveness from Member Characteristics." Psychological Bulletin 62(1964):248-256.

Hoffman, L.R. et al. "Valence in the Adoption of Solutions by Problem-Solving Groups." Journal of Personality and Social Psychology 6(1967):175-182.

Horney, K. New Ways in Psychoanalysis. New York: W.W. Norton, 1939.

House, R. "T-Group Education and Leadership Effectiveness: A Review." Personnel Psychology 20(1967):1-33.

Howells, J. Theory and Practice of Family Psychiatry. Edinburgh, United Kingdom: Oliver and Boyd, Ltd., 1968.

Issacs, G. "Team Conflict - A Recapitulation of Conflict in the Home." Dissertation Abstracts 25, 1965.

XUM

James, W. Principles of Psychology. Vol. I. New York: Dover Press, 1950.

Jessee, R. "Educating Nurses for Communication." International Nursing Review 12(1965):43-45.

Johnson, M. and Martin, H. "A Sociological Analysis of the Nurse Role." American Journal of Nursing 58(1958):373-377.

Jourard, S. "To Whom Can a Nurse Give Personalized Care?" American Journal of Nursing 58(1961):86-88.

Kahn, R. and Cannell, C. The Dynamics of Interviewing. New York: John Wiley and Sons, 1957.

Kalkman, M. Psychiatric Nursing. New York: McGraw-Hill, Inc., 1967.

Kerlinger, F. Foundations of Behavioral Research. New York: Holt, Rinehart and Winston, Inc., 1964.

Korman, A.K. "Self-Esteem as a Moderator in Vocational Choice." Journal of Applied Psychology 53(1969):188-192.

Kramer, M. and Baker, C. "The Exodus: Can Nursing Afford It?" Journal of Nursing Administration 1(1971):15-30.

Krech, D., et al. Individual in Society. New York: McGraw-Hill, Inc., 1962.

Kuhn, M. and McPartland, T. "An Empirical Investigation of Self-Attitudes." American Sociological Review 19(1954):68-76.

Lambertson, E. "Barrier to Comprehensive Care is Professionals' Self-Image." Modern Hospital 114(1970):118.

Lange, S. "Esalen - And Afterward." Nursing Outlook 18(1970):33-35.

Lee, P. "Current Changes in Collegiate Education." Journal of Dental Education 33(1969):344-349.

Leventhal, H. and Perloe, S. "A Relationship Between Self-Esteem and Persuasibility." Journal of Abnormal and Social Psychology 64(1962):385-388.

Levine, E. "Nurse Manpower." American Journal of Nursing 69(1969):290-296.

Lewin, K. A Dynamic Theory of Personality. New York: McGraw-Hill, Inc. 1935.

Lewin, K. and Grabbe, P. "Conduct, Knowledge and Acceptance of New Values." Journal of Social Issues 9(1945):56-64

Likert, R. "A Technique for the Measurement of Attitudes." Archives of Psychology Monograph No. 140, 1932.

McGarvey, M. and Wehrle, P. "Implications for the Curriculum of Educational Programs in the Health Sciences." USC-SMC Student Health Project Los Angeles, California: University of Southern California, 1966.

McKeachie, W. "Research on Teaching at the College and University Level." Handbook of Research on Teaching. Edited by N.L. Gage. Chicago: Rand-McNally and Co., 1963.

MacKinnon, D.W. "The Nature and Nurture of Creative Talent." American Psychologist 17(1962):484-495.

Macomber, F.G. and Siegel. "A Study of Large Group Teaching Procedures." Educational Research 38(1957):220-229.

Magraw, Richard. "Interdisciplinary Teamwork." Annals of Internal Medicine 69(1968):821-835.

Mauksch, H.O. "Becoming a Nurse: A Selected View." The Annals of the American Academy of Political and Social Science 346(1963):88-98.

Mauksch, I. "Collective Response to Occupational Grievance." Paper presented at the Sigma Theta Tau Session, N.L.N. Convention, Detroit, 20 May, 1969.

Mead, G.H. Mind, Self and Society. Chicago: University of Chicago Press, 1934.

Mednich, S.A. and Mednich, M.T. Remote Associates Test. Boston: Houghton Mifflin Co., 1967.

Mereness, D.A. "Recent Trends in Expanding Roles of the Nurse." Paper presented at the meeting of Baccalaureate and Higher Degree Programs, Hotel Muelbach, Kansas City, Missouri, 12 March, 1970.

Mereness, D. "Your Self-Image and Your Practice." American Journal of Nursing 66(1966):96-100.

Miles, M. "The T-Group and the Classroom." T-Group Theory and Laboratory Method. Edited by Bradford, Gibb and Benne. New York: John Wiley and Sons, 1964.

Moreno, J.L. Psychodrama. New York: Beacon House, 1945.

Morgan, C.T. and King, A. Introduction to Psychology. New York: McGraw-Hill, Inc., 1966.

Mosel, J.N. "The Learning Process." Journal of Medical Education 39(1964):5.

Muller, T.G. "Dynamics of Communication in Nursing." Journal of Nursing Education 1(1962):9-16.

Murphy, G. Personality: A Biosocial Approach to Origins and Structure. New York: Harpers, 1947.

Nie, N.H. et al. Statistical Package for the Social Sciences. New York: McGraw-Hill, Inc., 1970.

Nunnally, J.C. and Osgood, C.E. Popular Conceptions of Mental Health: Their Development and Change. New York: Holt, Rinehart and Winston, 1961.

Odiorne, G. "The Trouble with Sensitivity Training." Training Directors' Journal 17(1963):9-20.

Olesen, V. and Davis, F. "Baccalaureate Students' Images of Nursing." Nursing Research 15(1966):151-158.

Omwake, K.T. "The Relation Between Acceptance of Self and Acceptance of Others." Journal of Consulting Psychology 18(1954):443-446.

Orlando, I.J. The Dynamic Nurse-Patient Relationship: Function, Process and Principles. New York: G.P. Putnam's Sons, 1961.

Orzack, L.H. "Issues Underlying Role Dilemmas of Professionals." Emotional Factors in Public Health Nursing. Edited by A.B. Abromowitz. Madison: University of Wisconsin Press, 1961.

Osgood, C.E. et al. The Measurement of Meaning. Urbana: University of Illinois Press, 1957.

Page, E.B. "Ordered Hypothesis for Multiple Treatments: A Significance Test for Linear Ranks." Journal of American Statistical Association 58(1963):216-230.

Parson, T. The Social System. Glencoe: The Free Press, 1951.

Parsons, T. and Shils, E., eds. Toward a General Theory of Action. Cambridge: Harvard University Press, 1951.

Pellegrino, E.D. "The Changing Role of the Professional Nurse in the Hospital." Hospitals 35(1961):56-62.

Pellegrino, E.D. "The Communication Crisis in Nursing." Nursing Forum 5(1966):45-63.

Pellegrino, E.D. "Emphasis to Change in Health Care." NLN News 17(1969):11.

Raimy, V.C. "The Self-concept as a Factor in Counseling and Personality Organization." Ph.D. dissertation, Ohio State University, 1943.

Reader, G.G. "Content and Format in Interdisciplinary Teaching." Canadian Medical Association Journal 97(1967):718-719.

Reisman, L. and Rohrer, J. Change and Dilemma in the Nursing Profession. New York: Putnam, 1957.

XUM

Reitan, H. and Shaw, M. "Group Membership, Sex-composition of the Group, and Conformity Behavior." Journal of Social Psychology 64(1964):45-51.

Rogers, C.R. Client-Centered Therapy. Boston: Houghton Mifflin Co., 1951.

Rogers, C. "Client-Centered Therapy." American Handbook of Psychology, vol. 6. New York: Basic Books, 1966.

Rosenberg, M. Occupations and Values. Glencoe: Free Press, 1957.

Ruesch, J. "Social Process." Archives of General Psychiatry 15(1966): 577-589.

Ruesch, J. and Bateson, G. Communication: The Social Matrix of Psychiatry. New York: W.W. Norton, 1951.

Sarlien, R.R. and Allen, V.S. "Role Theory." Handbook of Social Psychology. Edited by G. Lindzey. Menlo Park: Addison-Wesley, 1958.

Satir, Virginia. Personal communication to the author, 1968.

Schellenberg, J.A. "Group Size as a Factor in Success of Academic Discussion Groups." Journal of Educational Sociology 33(1959):73-79.

Schulberg, H. et al, eds. Program Evaluation in the Health Fields. New York: Behavioral Publications, Inc., 1969.

Schulberg, H. and Baker, F. "Program Evaluation Models and the Implementation of Research Findings." American Journal of Public Health 58(1968):1248-1255.

Schutz, W.C. The Interpersonal Underworld. Palo Alto: Science and Behavior Books, 1966.

Seguin, C.A. "Groups in Medical Education." Journal of Medical Education 40(1965):281-285.

Shaw, M. and Wright, J. Scales for the Measurements of Attitudes. New York: McGraw-Hill, Inc., 1967.

Sheerer, E.T. "An Analysis of the Relationship of Acceptance of and Respect for Self and Acceptance of and Respect for Others." Journal of Consulting Psychology 13(1949):169-175.

Silverman, I. "Self-Esteem and Differential Responsiveness to Success and Failure." Journal of Abnormal and Social Psychology 69(1964): 115-119.

Smith, P. "Comparison of Factor Analytic Solutions." Journal of Abnormal and Social Psychology 64(1962):326-333.

Snygg, D. and Combes, A. Individual Behavior: A New Frame of Reference for Psychology. New York: Harpers, 1949.

Sorensen, E. "The Law, the Family: Evaluation of Conciliation." Unpublished, 1967.

Sorensen, E. et al. Communication and Human Systems. Final Report, NIMH, Division of Manpower and Training Programs, Experimental and Special Training Branch, Training Grant #10829, 1972.

Sorrells, J.M. and Ford, F.R. "Toward an Integrated Theory of Families and Family Therapy." Psychotherapy: Theory, Research and Practice 6(1969):150-160.

Stein, L. "The Doctor-Nurse Game." American Journal of Nursing 68(1968):101-105.

Stock, D. "A Survey of Research on T-Groups." T-Group Theory and Laboratory Method. Edited by Bradford, Gibb and Benne. New York: John Wiley and Sons, 1964.

Storlie, F. Nursing and the Social Conscience. New York: Appleton-Century-Crofts, 1970.

Stotland, E. and Hillmer, M., Jr. "Identification, Authoritarian Defensiveness, and Self-Esteem." Journal of Abnormal and Social Psychology 64(1962):334-342.

Strauss, A. and Glaser, B. Anguish: A Case History of a Dying Trajectory. Mill Valley: The Sociology Press, 1970.

Sullivan, H. Conceptions of Modern Psychiatry. New York: W.W. Norton, 1953.

Szasz, G. "Education for the Health Team." Canadian Journal of Public Health 61(1970);386-390.

Thompson, V.D. et al. "Sensitivity Training and Nursing Education: A Process Study." Nursing Research 14(1965):132-137.

Turk, H. and Ingles, H. Clinic Nursing: Exploration in Role Innovation. Philadelphia: Davis, 1963.

Tyler, R.W. "New Trends in Education." American Journal of Psychiatry 122(1966):1394-1398.

Vinacke, W.E. Foundations of Psychology. New York: American Book Co., 1968.

Wallen, N. and Travers, R. "Analysis and Investigation of Teaching Methods." Handbook of Research on Teaching. Edited by N.S. Gage. Chicago: Rand McNally and Co., 1963.

Watzlawick, P. et al. The Pragmatics of Human Communication. New York: W.W. Norton, 1967.

Wenkart, A. "Self-Acceptance." American Journal of Psychoanalysis 15(1955):135-143.

Western Interstate Commission for Higher Education. Reports on Higher Education, vol. XV 1(1968):8.

Wilcoxon, F. "Probability Tables for Individual Comparisons by Ranking Methods." Biometrics 3(1947):119-122.

Whitman, R.M. "Psychodynamic Principles Underlying T-Group Processes." T-Group Theory and Laboratory Method. Edited by Bradford, Gibb and Benne. New York: John Wiley and Sons, 1964.

Wylie, R.C. The Self Concept. Lincoln: University of Nebraska Press, 1961.

Yalom, I.D. et al. "The Use of Small Interactional Groups in the Teaching of Psychiatry." International Journal of Group Psychotherapy 15(1965):242-249.

Yalom, I. and Rand, K. "Compatibility and Cohesiveness in Therapy Groups." Archives of General Psychiatry 15(1966):267-275.

Yeaworth, R. "Learning Through Group Experience." Nursing Outlook 18(1970):29-32.

Young, L. "Nursing's Challenge." Nursing Outlook 17(1969):62-65.

Zander, A.; Cohen, A. and Stotland, E. Role Relations in the Mental Health Professions. Ann Arbor: University of Michigan, 1957.

XUM

APPENDICES

A. Sample Class Schedules

B. Brochure

C. Consent and Release Forms

D. Statements for Group Members

E. Structured Interview for Applicants

F. Quantitative Evaluation Instruments

G. Demographic Data-Study Groups

H. Post-Graduate Schedule

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APPENDIX A

Sample Class Schedules

Group #7

	Wednesday	Thursday	Friday
1)	1/7 (A & B) Staff & Group Introductions Video R.N. Conference	1/8 (A & B) 9:00 - 12:00 Orientation Evaluation 1:00 - 4:00 Communication Theory	1/9 (A & B) 9:00 - 12:00 T-Group Theory 1:00 - 4:00 Group Laboratory
2)	1/14 (A) 9:00 - 4:00 T-Group	1/15 (A & B) 9:00 - 12:00 Family Theory Lab 1:00 - 4:00 Communication Theory Evaluation	1/16 (B) 9:00 -4:00 T-Group
3)	1/21 (A) 9:00 - 4:00 Encounter (Bag lunch)	1/22 (A & B) 9:00 - 12:00 Family Theory Lab 1:00 -4:00 Communication Theory Evaluation	1/23 (B) 9:00 - 4:00 Encounter (Bag lunch)
4)	1/28 (A) Marathon	1/29	1/30 (B) Marathon
5)	2/4 9:00 - 2:00 Encounter (A) (Bag Lunch) 3:00 - 8:00 Encounter (B) (Bag lunch)	2/5 (A & B) 9:00 12:00 Family Theory Lab 1:00 4:00 Communication Theory	NO CLASS
6)	2/11 (A) 9:00 - 12:00 Satir Video 1:00 - 3:00 Family Research 3:00 - Jackson Film	2/12 (A & B) 9-12:00 Family Theory Lab 12:30 - Mid Evaluation 1 - 4:00 Communication Theory	2/13 (B) 9:00 - Jackson Film 10:30- 12:30 Family Research 1:00 - 4:00 Satir Video

Group #7

	Wednesday	Thursday	Friday
7)	2/18 (A) 9:00 - 4:00 Encounter	2/19 (A & B) 9:00 12:00 Family Theory Lab 1:00 -4:00 Communication Theory	2/20 (B) 9:00 -4:00 Encounter
8)	2/25 (A) 10:00 - 12:00 Brief Therapy Lab 1:00 - 4:00 Systems Lab	2/26 (A & B) 9:00 - 12:00 Family Theory Lab 1:00 -4:00 Communication Theory	2/27 (B) 9:00 - 12:00 Systems Lab 1:00 - 3:00 Brief Therapy Lab
9)	3/4 (A) 10:00 - 12:00 Brief Therapy Lab 1:00 - 4:00 Systems Lab	3/5 (A & B) 9:00 - 12:00 Family Theory Lab 1:00 -3:30 Systems Lab Evaluation	3/6 (B) 9:00 - 12:00 Systems Lab 1:00 -3:00 Brief Therapy Lab
10)	3/11 (A) 10:00 - 12:00 Brief Therapy Lab 1:00 - 3:30 Systems Lab Evaluation	3/12 (A & B) 9:00 - 2:00 Encounter - A 3:00 - 8:00 Encounter -B	3/13 (B) 9:00 - 12:00 Systems Lab 1:00 - 3:00 Brief Therapy Lab Evaluation
11)	3/18 (A) 9:00 - 12:00 Video 12:00 - 3:30 Encounter Evaluation	3/19 (B) 9:00 - 12:00 Video 12:00 - 3:30 Encounter Evaluation	3/20 (A & B) 9:00 - 11:30 Video Feedback 11:30 - 1:00 Lunch - Group Tape 1:00 -3:00 Evaluation Feedback 3:00 GRADUATION

Group #9

	Thursday	Friday		Thursday	Friday
1)	10/1 9:00 - Introductions 10:00 - Video 12:00 - Lunch 1:00 -4:00 Video Playback Discussion	10/2 9:00 -11:00 Orientation Evaluation 11:00 - 12:30 Systems Theory 1:30 - 4:00 Placement Conference	7)	11/12 8:30 - "Getting it Together" 10:00 -12:00 Brief Therapy Lab 1:00 -4:00 Family Lab	11/13 9:00 - 1:00 Systems Lab 2:00 - 4:00 T-Group
2)	10/8 9:00 - 12:00 Communication Theory 12:30 -3:30 Family Lab 3:30 Evaluation	10/9 9:00 - 11:00 System Theory 11:30 - Evaluation 12:00 -2:00 Community Systems 2:00 -4:00 T-Group	8)	11/19 8:30 - "Endings & Beginnings" 10;00 - 12:00 Brief Therapy Lab 1:00 - 4:00 Family Lab	11/20 9:00 - 1:00 Systems Lab 2:00 -4:00 T-Group
3)	10/15 9:00 - 12:00 Communication Theory 1:00 -4:00 Family Lab	10/16 9:00 - 12:00 Communication Games 12:45 - Group Discussion 2:00 -4:00 T-Group	9)	11/26 THANKSGIVING	11/27
4)	10/22 9:00 - 12:00 Communication Theory 1:00 - 4:00 Family Lab	10/23 9:00 - 1:00 Multiple Systems 2:00 -4:00 T-Group	10)	12/3 9:00 - 12:00 Communication Theory 1:00 - Family Research Evaluation	12/4 9:00 - 1:00 Systems Lab 2:00 -4:00 T-Group
5)	10/29 9:00 - 12:00 Communication Theory 1:00 - 4:00 Family Lab	10/30 9:00 - 11:30 Satir Video 12:15 - Jackson Film 2:00 - 4:00 T-Group	11)	12/10 9:00 Video & Discussion 3:30 - Evaluation	12/11 9:00 - Video Discussion 11:30- Group Tape 1:00 - Evaluation Feedback 3:00 - GRADUATION
6)	11/5 8:30 - Field Talk 10:00 - 12-00 Brief Therapy Lab 4:00 Mid Evaluation	11/6 Marathon			

Group #12 Summer Workshop

	Monday	Tuesday	Wednesday	Thursday	Friday
1)	7/12 9:00 - Registration Introduction 10:00 - Video/Discussion	7/13 9:00 - Evaluation 10:00 -12:00 Systems Theory 1:00 - 4:00 Communication Games	7/14 9:00 - Evaluation 10:00 -12:30 Family Theory Lab 1:30 -3:30 T-Group	7/15 9:00 - 12:00 Communication Theory 1:00 -4:00 Systems Lab	7/16 9:00 -12:30 Family Therapy Lab 1:30 -3:30 T- Group
2)	7/19 9:00 - 12:00 Communication Theory 1:00 -4:00 Group Time	7/20 9:00 -12:00 Group Time 1:00 -4:00 Personal and Community Systems	7/21 9:00 -12:30 Family Therapy Lab 1:30 - 3:30 T-Group	7/22 10:00 - 12:00 Brief Therapy Lab 1:00 -4:00 Systems Lab	7/23 9:00 -12:30 Family Therapy Lab 1:30 - 3:30 T-Group
3)	7/26 9:00 -12:00 Communication Theory 1:00 -4:00 Group Time	7/27 9:00 -12:00 Group Time 1:00 -4:00 Personal and Community Systems	7/28 9:00 - 12:30 Family Therapy Lab 1:30 -3:30 T- Group	7/29 10:00 - 12:00 Brief Therapy Lab 1:00 -4:00 Systems Lab	7/30 10:00 - 12:00 Brief Therapy Lab 1:30 - 3:30 T- Group
4)	8/2 9:00 -12:00 Communication Theory 1:00 -4:00 Group Time	8/3 9:00 -12:00 Satir Video 1:00 -4:00 Group Time	8/4 9:00 -12:30 Family Therapy Lab 1:30 -3:30 T- Group	8/5 9:00 Evaluation Video and Discussion	8/6 9:00_ Video Playback 11:30- Group Tape 1:00 Evaluation & Feedback 3:00 - GRADUATION

APPENDIX B

Brochure

COMMUNICATION & HUMAN SYSTEMS PROGRAM

A COURSE BASED ON FAMILY THERAPY THEORY

SPONSORS

The Mental Research Institute, a multi-disciplinary, non-profit organization developed for research and training in the fields of communication and interaction in families and other social systems.

The National Institute of Mental Health, Division of Manpower and Training Programs, Experimental and Special Training Branch.

Training Grant No. MH 10829

FACULTY

Director:

Elaine Sorensen, R.N., M.S., Clinical Associate – MRI

Instructors:

Arlene Bruinsma, R.N., M.S.
Harris Clemes, Ph.D.
Mary Delehanty, R.N.
Richard Fisch, M.D.
Joan Herrick, M.S.S.
Sheldon Starr, Ph.D.
Paul Watzlawick, Ph.D.
John Weakland

A TRAINING PROGRAM IN COMMUNICATION AND HUMAN SYSTEMS

This interdisciplinary, coeducational, program is designed to increase theoretical and experiential understanding of:

one's own uniqueness as it contributes to personal and professional effectiveness

individual and group behavior

a general systems, or cybernetic, grasp of interpersonal behavior

the implications of systems and role theory for interdisciplinary cooperation

relevant evaluation and research activities and applications

This program is also designed to foster the integration and application of this learning experience in personal and professional effectiveness

In implementing these goals, the intensive three-month course will incorporate a variety of learning experiences, including lectures, seminars, encounter groups, role-playing, demonstrations, and field placements. Observation suites, audio and videotaping facilities, off-prints, and professional library will also be utilized in training.

Students will receive a certificate upon satisfactory completion of the program.

GENERAL DESCRIPTION

Program

The program, scheduled on an academic quarter basis, is offered in the fall, winter and spring.

Each class will be limited in size. The majority of students will be from the nursing profession with additional class members to be drawn from other disciplines.

The program will be scheduled Monday through Friday with approximately half-time to be spent at the Mental Research Institute and half time in field placement agencies. Field placement will be at agencies in San Mateo and Santa Clara counties.

Stipends

Nurses who are accepted will be awarded tuition and fees in addition to stipends.

Transportation

Each trainee is responsible for his own round-trip transportation to the Mental Research Institute as well as travel to and from the field placement agencies. Since public transportation in California is somewhat limited, trainees should anticipate owning or leasing an automobile.

Housing

Each trainee is responsible for his own housing.

Appendix B

Application Card

COMMUNICATION & HUMAN SYSTEMS PROGRAM

Name_____

Attach recent photo.

Home Phone: (_____) _____
area code

Home Address: _____

_____
zip code

Work Phone: (_____) _____
area code

What do you expect to gain from this experience?

Work Address _____

_____
zip code

Please check your preferred mailing address

Age _____ Sex _____ Marital Status _____

Social Security No. _____

Place of Birth _____

Date of Birth _____
Mo. Day Year

Spouse's Name: _____ Age _____

Work: _____

Children's ages: _____

References: (from your two most recent work experiences)

1 _____

How do you anticipate using what you gain from this experience?

_____

_____

2. _____

_____

_____

(The following item for nurse applicants)

Current Registration Number(s) State(s)

_____ _____

_____ _____

Date of program for which you are applying _____

MENTAL RESEARCH INSTITUTE
555 Middlefield Road, Palo Alto, Calif. 94301

APPENDIX C

Consent and Release Forms

Appendix C

For Trainees

CONSENT AND RELEASE

Mental Research Institute
555 Middlefield Road
Palo Alto, California 94301

THE UNDERSIGNED hereby voluntarily consents and permits personnel of MENTAL RESEARCH INSTITUTE, and its authorized agents to observe, record and reproduce some or all of the sessions in which I will participate and be involved. I am informed that the recordings may consist of audio tape, video tape, motion picture, or other means of recording these sessions, and that they may be reproduced. I further understand that I may be requested from time to time to participate in various psychological tests. I hereby consent to such testing.

I further consent to the use by the personnel of MENTAL RESEARCH INSTITUTE, its successors, assigns and duly authorized agents, of the observations, recordings and reproductions of the sessions in which I participate, and the psychological tests given to me, for the purpose of research, teaching, clinical reporting and investigation, professional investigation, publication in books or journals or any other use associated with professional activities.

I also acknowledge that I have been advised that it is the intention of MENTAL RESEARCH INSTITUTE to conduct as part of my training, some supervised field work and a group experience laboratory to which I give my consent and from which I release MENTAL RESEARCH INSTITUTE, or its successors, or assigns, and its employees, teachers or other agents, from all liability whatsoever.

I give the foregoing consent upon the assurance that MENTAL RESEARCH INSTITUTE, its personnel, agents, successors and assigns will use reasonable means to delete any references which will in any way identify the participants, but I acknowledge that it is impossible to assure me completely that my identity will not be revealed. I release MENTAL RESEARCH INSTITUTE, its personnel, agents, successors or assigns, from all liability and claim whatsoever with respect to any use of the sessions in which I participate and the psychological tests taken by me.

Dated at Palo Alto, California, this ____ day of _____.

WITNESS: _____

_____

Appendix C

For Demonstration Families

CONSENT AND RELEASE

Mental Research Institute
555 Middlefield Road
Palo Alto, California 93401

THE UNDERSIGNED hereby voluntarily consent and permit personnel of MENTAL RESEARCH INSTITUTE and its authorized agents to observe, record, and reproduce some or all of the sessions in which we and the minor children whose names are listed herein, will participate and be involved. We are informed that the recordings may consist of audio tape, video tape, motion picture, or other means of recording these sessions, and that they may be reproduced. We further understand that any of us may be requested from time to time to participate in various psychological tests. We hereby consent to such testing.

We further consent to the use by the personnel of MENTAL RESEARCH INSTITUTE, its successors, assigns, and duly authorized agents, of the observations, recordings and reproductions of the sessions in which we participate, and the psychological tests given to us, for the purposes of research, teaching, clinical reporting and investigation, professional investigation, publication in books or journals or any other use associated with professional activities.

We give the foregoing consent upon the assurance that MENTAL RESEARCH INSTITUTE, its personnel, agents, successors and assigns will use reasonable means to delete any references which will in any way identify the participants, but we acknowledge that it is impossible to assure us completely that our identity and that of our minor children will not be revealed. We release MENTAL RESEARCH INSTITUTE, its personnel, agents, successors or assigns from all liability and claim whatsoever with respect to any use of the sessions in which we participate and the psychological tests taken by us.

Dated at Palo Alto, California, this ____ day of _____, 19___.

WITNESS: _____

_____ _____

_____

MINOR CHILDREN:

_____

_____

_____

_____

APPENDIX D

Statements for Group Members

Appendix D

GROUP EXPERIENCE LABORATORY-- A STATEMENT FOR GROUP MEMBERS

A delineated, voluntary group experience which attempts to bridge theory and practice through constructive interactions, will be provided as an integral part of the CHS training program.

GOALS

All people are blocked, at least in some ways, from seeing new alternatives, from responding creatively to unusual and ambiguous situations, and from feeling alive and involved, because they are locked into habitual ways of thinking and acting. These taught and drilled perspectives of the world allow for efficiency in a well routinized, scheduled setting, but may bind one to impotence when the unexpected arrives. One goal of the group experience laboratory is to examine and shake up these frameworks, allowing the person to contact hidden feelings, ideas, and reactions, and experience new ways of relating and using himself. This normally leads to his feeling more free, spontaneous, and alive.

Another goal is to increase the person's awareness of his and others' avoidances, manipulations and distortions. Along with this awareness can come a willingness to take risks of being direct, involved intensively in relationships, open to what one is feeling and to what the other person is really trying to communicate.

Essentially, the aim is to increase one's honesty with oneself, to expand one's own perceptions and to appreciate his and others' uniqueness. When one gains deeper trust in broadened aspects of self, then it is easier to commit one's self to others, to become aware of where the other person is at psychologically, and to act with integrity.

TECHNIQUES

Orientation with opportunity for free questioning by trainees as a group or individually, will be provided in advance. The explicit and implicit aspects of the contract between MRI, the project staff, and trainees in reference to the group experiences will be delineated at this time.

Since this is to be at all times a voluntary educational growth experience directed toward strengthening personal understanding and capacity to use one's self effectively in interpersonal relations, particular techniques will be chosen to accomplish these goals. Depending upon the characteristics of the individuals and the groups, any or all of the following techniques will be utilized.

Phantasy explorations
Simulated situations
Sensory awareness
Self-exploration through art media
Focused interaction

Appendix D

CHS GROUP EXPERIENCE LABORATORY--A STATEMENT FOR GROUP MEMBERS

A twenty-four hour group experience laboratory will be held either at MRI, or--with the approval of the MRI director--at an alternate site selected by the trainees. The setting will afford privacy, safety, inexpensive transportation, and all necessary conditions to ensure appropriate personal comfort.

The leader is commited in principle to the use of humane techniques that will support the individual in personal growth and will protect his personal and civil rights. This presupposes that the leader will maintain sensitive awareness and leadership responsibility in optimizing individual and group potentials. He will avoid techniques that would test the limits of, or exceed, physical and psychological tolerance. Through his guidance and direction, the leader will at all times work to provide an environment of trust in which individual action and group processes, even those that might involve some discomfort or pain, will foster personal development.

The leader will also provide opportunities for the trainees to be aware that they are responsible for their own behavior. Personal integrity comes from taking responsibility for themselves, while sharing it with their leader.

In providing growth experiences, the leader will be aware also, of the importance of integration of the personal and group experiences with everyday life, and establish opportunities for trainees to make meaningful connections, to "tie-up" loose ends and to secure follow-up counseling and assistance as desired and needed.

APPENDIX E

Structured Interview for Applicants

Appendix E

COMMUNICATION & HUMAN SYSTEMS PROGRAM

Interview

1. What is you name?

2. What would you like to accomplish in this Communication & Human Systems Program: (a) Professionally? (b) Personally?

3. What about yourself particularly suits you for this kind of learning experience?

4. What is there about you that might stand in your way of using this as a growth experience?

5. Give two or three examples of personal problems with which you are currently struggling, and ways you expect to deal with them.

6. The Communication & Human Systems Program is a highly personal experience If any of your above problems becomes aggravated during the course, what do you think you might do?

7. If you are married, why?
   If you are not married, why not?
   If you are or have been divorced, how did the divorce come about?

8. Is your primary sex orientation toward (a) self, (b) the opposite sex, (c) the same sex, (d) none?

9. Group process is a fundamental component of the Communication & Human Systems Program. What would be your response to (a) encounter groups? and (b) group marathon?

10. With whom in your family have you discussed your participation in the Communication & Human Systems Program? What were the results of those discussions?

11. What questions do you have?

Appendix E

Suggestions for interpreting the interview so as to make your feedback most valuable for our purposes.

As a ground rule, people who say "nothing" in answer to #3 and #4 and who have no questions (#11) are out. Our hunch is that a person who says "nothing" to #3 probably has too little self-esteem; a person who says "nothing" to #4 is probably not sufficiently observant or doubtful about self and a person who says "none" to #11 probably won't give or get much feedback.

Further Guidelines

We generally want:

a. People who can acknowledge some areas of moderately low self-esteem.
b. People who are upward striving and moderately dissatisfied.
c. People who can recognize and acknowledge existing gaps in their experience.
d. People who are seeking direct ways to grow.
e. People who can talk precisely, succinctly, and directly or can be taught to talk precisely, succinctly and directly.
f. People who can give feedback (see above) "Do you have any questions?"
g. People who have some awareness that training may involve some growing pains.
h. People who are curious and are open to new experience.

We generally do not want:

a. Brittle, suspicious, compusive people.
b. People under 25 (too little experience in living), or over 45-50 (too much investment in the "status quo".) With this age group, please try to assess the risk that a major depression may be in the offing).
c. People who project an impression of having already reached highest degrees of competence in profession of life.
d. People who deny and project a great deal (infantile).
e. People who have tried out many different professional identities and really are none.
f. People who have moved around almost continuously.
g. People who resolve the self/other dilemma in favor of self the majority of the time.
h. People who dare us to teach them.

APPENDIX F

Quantitative Evaluation Instruments

PLEASE NOTE:

Pages 148-174, Appendix F:
"Remote Associates Test",
not microfilmed at request
of author. Available for
consultation at the Library
of the University of San
Francisco Medical Center.

UNIVERSITY MICROFILMS.

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APPENDIX G

Demographic Data-Study Groups

Appendix G

Demographic Data - Study Groups

	STUDENT	AGE	SEX	DEGREE	SPECIALITY	RESIDENCE
GROUP ONE	A1	28	F	BS,MS	Psychiatric Nursing	Palo Alto
	A2	40	F	BS	Public Health	Vallejo
	A3	41	F	BS, M.ED.	School Health	Los Altos
	A4	44	F	Diploma	Psychiatric Nursing	Washington
	A5	50	F	Diploma	Nursing Service	Portola Valley
	A6	25	M	MA	Group Psychology	San Jose
	A7	25	M	BA	Theology Student	Berkeley
	A8	33	M	BA,MBA, BD	Theology	Berkeley
	A9	35	M	Ph.D.	Psychology	Palo Alto
GROUP TWO	B1	24	F	BS	Psychiatric Nursing	Los Altos
	B2	28	F	BS	Psychiatric Nursing	Richmond
	B3	34	F	BA	Mental Health Nursing	San Jose
	B4	34	F	BS	Nursing Research	Palo Alto
	B5	34	F	BS	Public Health Nursing	Sunnyvale
	B6	35	F	BS	Public Health Nursing	Mt. View
	B7	40	F	BA,BS	Psychiatric Nursing	Menlo Park
	B8	26	M	BA	Group Psychology	San Jose
	B9	32	M	BA	Penology	San Jose
	B10	34	M	AA	Business Administration	Burlingame
	B11	35	M	BA	Penology	San Mateo
	B12	46	M	Ph.D.	Psychology	Sunnyvale
	B13	59	M	BA	Industrial Training	San Jose
GROUP THREE	C1	24	F	BS, MS	Psychiatric Nursing	Palo Alto
	C2	30	F	BS,MA	Nursing Education	San Jose
	C3	40	F	BS	Psychiatic Nursing	San Jose
	C4	41	F	Diploma	Psychiatric Nursing	Palo Alto
	C5	54	F	BA	Psychiatric Nursing	San Francisco
	C6	60	F	BS,MA	Nursing Administration	Palo Alto

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Appendix G

	STUDENT	AGE	SEX	DEGREE	SPECIALITY	RESIDENCE
Group Three	C7	23	M	BS, MA cand.	Psychology	San Jose
	C8	32	M	BA	Psychology	San Jose
	C9	32	M	BA	Psychology	Belmont
	C10	33	M	BA	Education	Palo Alto
	C11	35	M	BA	Penology	Palo Alto
	C12	45	M	BA	Penology	Belmont
Group Four	D1	35	F	BS	Nursing	Palo Alto
	D2	50	F	Diploma	Nursing	Palo Alto
	D3	31	F	BS, MS	Psychiatric Nursing	San Francisco
	D4	37	F	BS	School Nursing	Redwood City
	D5	30	F	BS, MS	Psychiatric Nursing	Hayward
	D6	48	F	BS, MS	Psychiatric Nursing	Iowa
	D7	27	F	Diploma	Psychiatric Nursing	Los Altos
	D8	36	M	BA	Corrections	San Jose
	D9	33	M	BA	Sociology	San Mateo
	D10	42	M	Ed.D.	Guidance & Counseling	Palo Alto
	D11	47	M	MA, Phd(c)	Psychology	New York
	D12	46	M		Law Enforcement	Palo Alto
	D13	25	M	MSW	Social Work	Palo Alto
	D14	31	M	M.S.	Juvenile Probation	San Leandro
Group Five	E1	47	F	BS, MA	Health Education	Menlo Park
	E2	39	F	BS, MPH	Community Mental Health	Michigan
	E3	31	F	BS, MS	Psychiatric Nursing	San Rafael
	E4	27	F	BS, MS	Psychiatric Nursing	Kentucky
	E5	36	F	BS, MS	Counseling & Guidance	Wisconsin
	E6	26	F	BS, M.ED	Counseling & Guidance	Pennsylvania
	E7	49	F	BS, MA	Education	Palo Alto
	E8	33	M	BA	Juvenile Probation	San Jose
	E9	38	M	MS	Sociology	San Jose
	E10	25	M	BA, Ph.D.(c)	Clinical Pyschology	San Francisco
	E11	29	M	MS	Psychiatry	Palo Alto
	E12	42	M	BA	Psychology	San Mateo
	E13	33	M	BS, MA	Psychiatric Nursing	Alviso
	E14	31	M	BA	Criminology	San Leandro

Appendix C

	STUDENT	AGE	SEX	DEGREE	SPECIALITY	RESIDENCE
	F1	46	F	M.A.	Education	New York
	F2	28	F	B.S.	Public Health Nursing	Saratoga
	F3	45	F	M.S.	Psych. Nursing	Palo Alto
	F4	62	F	M.S.	Pediatric Nursing	San Jose
	F5	35	F	M.P.H.	Public Health Nursing	Minnesota
	F6	65	F	M.A.	Psych. Nursing	San Francisco
	F7	48	F	M.A.	Nursing	Santa Clara
	F8	39	F	B.A.	Psychology	New York
	F9	37	F	M.A.	Psych. Nursing	San Jose
	F10	29	F	B.S.	Psych. Nursing	San Jose
Group Six	F11	25	M	Ph.D. (cand)	Psychology	Tennessee
	F12	33	M	M.A.	Drug Abuse	San Francisco
	F13	30	M	B.A.	Probation	Berkeley
	F14	37	M	B.A.	Juvenile Probation	Belmont
	F15	44	M	A.B.	Adult Probation	San Mateo
	F16	26	M	Ph.D. (cand)	Psychology	Connecticut
	F17	40	M	B.A.	Probation	San Jose
	F18	48	M	M.D.	Internal medicine, allergies	Palo Alto
	F19	45	M	B.A.	Community Ed.	Orinda
	F20	33	M	B.A.	Juvenile Probation	San Jose
Group Seven	G1	29	F	M.S.	Psych. Nursing	Indiana
	G2	25	F	B.S.	Nursing	Pennsylvania
	G3	29	S	B.S.	Nursing Education	San Francisco
	G4	24	S	B.S.	Nursing	Michigan
	G5	24	F	M.S.	Psych. Nursing	Berkeley
	G6	37	F	M.S.	Nursing Education	San Francisco
	G7	55	F	B.S.	Public Health Nsg.	Nevada City
	G8	22	F	B.S.	Nursing Education	New York
	G9	43	F	M.S.	Psych. Nursing	Bakersfield

Appendix G

	STUDENT	AGE	SEX	DEGREE	SPECIALTY	RESIDENCE
Group Seven	G10	30	M	A.A.	Nursing	San Jose
	G11	35	M	B.A.	Probation	San Mateo
	G12	33	M	M.S.	Probation	San Jose
	G13	50	M	Ph.D.	Psychology	Florida
	G14	25	M	Ph.D. (C)	Psychology	Texas
	G15	29	M	B.A.	Probation	Hayward
	G16	34	M	B.A.	Probation	San Jose
	G17	25	M	Ph.D. (C)	Psychology	Tennessee
	G18	38	M	Th.M.	Probation	San Mateo
Group Eight	H1	28	F	B.S.	Drug Abuse	San Jose
	H2	42	F	M.S.	Psych. Nursing	San Jose
	H3	43	F	M.N.	Psych. Nursing	San Francisco
	H4	24	F	M.S.	Child Psych. Nursing	Palo Alto
	H5	28	F	B.S.	Psych. Nursing	Colorado
	H6	29	F	M.Ed.	Psych. Nursing	Tennessee
	H7	54	F	M.A.	Education	Minnesota
	H8	46	F	M.A.	Nursing Ed.	San Jose
	H9	43	F	Ph.D. (C)	Nursing Research	New York
	H10	32	F	M.S.N.	Psych. Nursing	San Francisco
	H11	41	M	M.A.	Education	San Mateo
	H12	47	M	B.A.	Probation	San Mateo
	H13	43	M	R.N.	Psych. Nursing	San Francisco
	H14	23	M	Ph.D. (C)	Psychology	Massachusetts
	H15	32	M	B.S.	Probation	Oakland
	H16	28	M	Ph.D. (C)	Psychology	Nebraska
	H17	31	M	B.A.	Probation	San Jose
	H18	27	M	Ph.D. (C)	Psychology	Washington
	H19	35	M	B.A.	Probation	San Jose
	H20	43	M	M.A.	Probation	San Mateo

Appendix G

	STUDENT	AGE	SEX	DEGREE	SPECIALITY	RESIDENCE
GROUP NINE	I1	23	F	M.S.	Psych. Nursing	Palo Alto
	I2	25	F	M.S.	Psych. Nursing	Minnesota
	I3	28	F	M.S.	Psych. Nursing	San Jose
	I4	51	F	M.S.	Psych. Nursing	Moraga
	I5	36	F	M.N.	Nursing	
	I6	43	F	B.S.	Nursing	San Jose
	I7	36	M	Ph.D. (C)	Psychology	Texas
	I8	39	M	B.A.	Probation	San Jose
	I9	30	M	M.A.	Ministry	New Mexico
	I10	35	M	B.A.	Probation	Massachusetts
	I11	25	M	Ph.D. (C)	Psychology	San Mateo
	I12	38	M	MSW	Probation	Stockton
	I13	34	M	R.N.	Psych. Nursing	
GROUP TEN	J1	46	F	Ph.D.	Epidemiology	North Carolina
	J2	32	F	Ph.D. (C)	Psych. Nursing	San Francisco
	J3	33	F	M.S.	Comm. Mental Hlth.	San Jose
	J4	30	F	M.S.	Psych. Nursing	San Francisco
	J5	43	F	M.A.	School Nursing	New Jersey
	J6	47	F	M.A.	Maternal & Child	Michigan
	J7	30	F	M.A.	Psych. Nursing	San Francisco
	J8	39	M	B.A.	Probation	San Mateo
	J9	28	M	Ph.D. (C)	Psychology	Nevada
	J10	50	M	S.W.C.	Social Work	San Mateo
	J11	38	M	B.S.N.	Nursing	Stockton
	J12	26	M	M.A. (C)	Guidance & Counseling	San Francisco
	J13	46	M	M.A.	Education	San Mateo
	J14	27	M	Ph.D. (C)	Psychology	Illinois

Appendix G

	STUDENT	AGE	SEX	DEGREE	SPECIALITY	RESIDENCE
GROUP 11	K1	34	F	M.S.	Nursing Ed.	Los Altos
	K2	26	F	M.S.	Pediatric Nsg.	Iowa
	K3	33	F	M.S.N.	Psych. Nursing	San Diego
	K4	39	F	M.Ed.	Nursing Ed.	North Carolina
	K5	39	F	M.S.	Nursing	San Francisco
	K6	23	F	M.S.	Psych. Nursing	Menlo Park
	K7	26	F	M.D.	Psychiatry	San Francisco
	K8	35	F	M.S.	Psych. Nursing	South Carolina
	K9	27	M	B.A.	Psychology	San Mateo
	K10	46	M	B.A.	Probation	San Mateo
	K11	34	M	Ph.D.	Psychology	San Jose
	K12	38	M	M.S.	Theology	Dublin
	K13	41	M	Dip.Ed.	Psychology	Australia
	K14	40	M	M.A.	Probation	Palo Alto
GROUP 12	L1	48	F	R.N.	Drug Abuse	New Mexico
	L2	52	F	M.Litt.	Psych. Nursing	Hawaii
	L3	32	F.	M.S.	Comm. Mental Health	Hawaii
	L4	35	F. ..	M.S.	Psych. Nursing	Colorado
	L5	34	F	M.S.	Psych. Nursingq	Colorado
	L6	26	F	M.S.	Nursing	Palo Alto
	L7	29	F	M.S.	Maternal/Child Nsg.	Wisconsin
	L8	55	M	M.S.W.	Social [redacted]	San Mateo
	L9	29	M	M.A.	Psychology	Canada
	L10	23	M	M.A.	Counseling Psych.	Palo Alto
	L11	27	M	Ph.D. (C)	Psychology	Arizona
	L12	51	M	M.H.L	Rabbi	San Mateo
	L13	43	M	Ph.D. (C)	Psychology	Georgia
	L14	35	M	M.D.	Psychiatry	San Francisco

APPENDIX H

Post-Graduate Schedule

CHS Post-Graduate Group II

Thursday	Friday			Friday		
2/3 Secs. A & B	2/4	(A)	(B)	3/10	(A)	(B)
12:30 - Introductions	9:00-12:30	Family Lab	Brief Therapy Lab	9:00-12:30	Family Lab	Brief Therapy Lab
1:00 - 3:00 Video					Lunch	
	12:30	Bag Lunch Staff & Trainees		1:30-3:30	T-Group (A & B)	
3:00 -4:30 Evaluation	1:30 - 3:30	T-Group (A & B)		3:30	Evaluation	
	2/11	(A)	(B)	3/17	(A)	(B)
	9:00-12:30	Family Lab	Brief Therapy Lab	9:00-12:30	Family Lab	Brief Therapy Lab
		Lunch		12:30-	Bag Lunch Staff & Trainees	
	1:30-3:30	T-Group (A & B)		1:30-3:30	T-Group (A & B)	
	3:30	Evaluation				
	2/18	(A)	(B)	3/24	(A)	(B)
	9:00-12:30	Family Lab	Brief Therapy Lab	9:00-12:30	Family Lab	Brief Therapy Lab
	12:30	Bag Lunch Staff & Trainees			Lunch	
	1:30-3:30	T-Group (A & B)		1:30-3:30	T-Group (A &B)	
				3:30-	Evaluation	
	2/25	(A)	(B)	3/31	Secs. A & B	
	9:00 - 12:30	Family Lab	Brief Therapy Lab	9:00	Video & Discussion	
		Lunch		12:00	Group Tape	
	1:30-3:30	T-Group (A & B)		12:30	Lunch	
	3:30	Evaluation		2:00	Evaluation Feedback	
				3:00	GRADUATION	
	3/3	(A)	(B)			
	9:00 - 12:30	Family Lab	Brief Therapy Lab			
	12:30	Bag Lunch Staff & Trainees				
	1:30-3:30	T-Group (A & B)				